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I. INTRODUCTION

The ongoing debate in the United States about the legality and use of medical marijuana (also known as medicinal cannabis) is intriguing.[1] There are those who would like to prevent, control, or even outright ban the use of medical marijuana. On the other hand, there are those who advocate for the legalization of medical marijuana in order to treat a variety of medical conditions, including debilitating diseases like AIDS, cancer, epilepsy, and chronic acute pain. Thrown into this debate is the conflicting treatment of marijuana by state and federal law. Marijuana is an illegal drug under federal law.[2] The Controlled Substances Act (CSA), enacted in 1970, which outlawed marijuana and declared that it had no accepted medical use,[3] also classifies marijuana as a Schedule I drug.[4] Schedule I is the most dangerous category and

1. The term "medical marijuana" is used in this article to refer to the whole unprocessed marijuana plant or to its crude extracts, which are not recognized or approved as medicine by the U.S. Food and Drug Administration (FDA). However, scientific study of the active chemicals in marijuana (cannabinoids) has led to the development of two FDA-approved medications (Marinol and Cesamet) in the race to develop new pharmaceuticals that will take advantage of the therapeutic benefits of cannabinoids, but will minimize or eliminate the harmful side effects from eating or smoking raw marijuana. *See Drug Facts: Is Marijuana Medicine?*, NIH NAT'L INST. ON DRUG ABUSE: THE SCIENCE OF DRUG ABUSE AND ADDICTION, http://www.drugabuse.gov/publications/drugfacts/marijuana-medicine (last updated July 2015).

2. Controlled Substances Act (CSA), 21 U.S.C. §§ 801–971 (2000).

3. Today, however, this proposition is becoming a less supported notion as states continue to adopt laws allowing for medical marijuana use. *See* Michael J. Aurit, *Reefer Sadness: How Patients Will Suffer if Arizona Refuses to Implement Its Own Medical Marijuana Law*, 5 PHOENIX L. REV. 543, 548–53 (2012).

4. 21 U.S.C. §§ 812(b)(1), (c)(c)(17) (2000).

includes heroin, LSD, and ecstasy.[5] This classification has been upheld even in the face of radical social changes in favor of legalization.[6] Most recently, in the 2005 case of *Gonzales v. Raich*, the United States Supreme Court held that it is illegal to use, sell, or possess marijuana for medical use, even if the medical use is approved by the state and is in compliance with state law.[7]

Although many states follow this Supreme Court ruling, a growing number have legalized the use and cultivation of marijuana for medicinal purposes.[8] There are laws authorizing some legal form of medical marijuana in twenty-three states.[9] Yet, state laws do not provide a carte blanche to citizens.[10] States limit the circumstances and conditions under which medical marijuana may be cultivated, possessed, and used.[11] Even with these limitations, these state laws invariably contradict federal law, given that the latter makes it a crime to cultivate, possess, or use marijuana for any purpose.[12]

Courts and legal scholars are grappling with the question of whether the CSA preempts state marijuana laws, thereby rendering those state laws legalizing marijuana void.[13] Some courts have held

5. Aurit, *supra* note 3, at 550; Kevin A. Sabet, *Much Ado About Nothing: Why Rescheduling Won't Solve Advocates' Medical Marijuana Problem*, 58 WAYNE L. REV. 81, 82–84 (2012).

6. *See infra* Part VI (discussing the evolution of state and federal policies regarding marijuana legalization and the federal government's steadfast position that marijuana is an illegal Schedule I drug).

7. 545 U.S. 1, 29 (2005). California passed the Compassionate Use Act in 1996 which allowed for the use of medical marijuana. *Id.* at 5–6. The defendants were using marijuana properly under the Compassionate Use Act and one was growing marijuana plants at home for personal use, while the other relied on a third party for locally grown marijuana provided at no charge. *Id.* at 6–7. Federal DEA agents seized and destroyed their marijuana plants. *Id.* at 6–7. The defendants were compliant with state laws when arrested but guilty under federal DEA laws at the time. *Id.* at 7. The defendants sued the Attorney General, arguing that Congress had exceeded its Commerce Clause authority by legislating the behavior of a local citizen consuming a locally grown herb in his own home. *Id.* The Supreme Court held that the Commerce Clause authorized Congress to prohibit the local cultivation and use of marijuana in compliance with California law. *Id.* at 29. For further discussion of this case, *see infra* Section VII.A.

8. *See infra* Table: Medical Marijuana Laws by State.

9. *See infra* Table: Medical Marijuana Laws by State.

10. *See infra* Table: Medical Marijuana Laws by State.

11. *See infra* Table: Medical Marijuana Laws by State.

12. *See* Aurit, *supra* note 3, at 553.

13. Michael A. Cole, Jr., Note, *Functional Preemption: An Explanation of How*

medical marijuana statutes invalid under the theory that they are preempted by the CSA, while other courts have found that state laws are not preempted by the CSA[14] and, as such, found some states medical marijuana laws to be enforceable.[15]

Also, given the principle that federal law preempts state law, an important legal question now is the status of users of medical marijuana in states that do not conform to the federal law.[16] The status of those medical marijuana users who are in compliance with state law in their use of marijuana, yet are in violation of federal law, is a tenuous one.[17] Should the federal government enforce its own laws by investigating and prosecuting those who follow their state marijuana laws? Or should it exercise its investigatory and prosecutorial discretion and refrain from enforcing federal law? Another important issue is whether there is indeed momentum growing for deference towards state action, and if so, what should the role of the federal institutions, especially the Department of Justice (DOJ), be in shaping national policy?

This article will also examine the social, economic, and legal pros and cons of legalization of medical marijuana to highlight the effects of medical marijuana legalization on the economy of a state.[18] In sum, this paper looks at the current conundrum medical marijuana is in as it is stuck in the legal conflicts between state and federal laws in order to extrapolate some conclusions about the legal future of medical marijuana.[19]

Particular cases are examined in order to demonstrate the influence of marijuana policies as a whole.[20] In sum, this paper

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State Medicinal Marijuana Laws Can Coexist with the Controlled Substances Act, 16 MICH. ST. U. J. MED. & L. 557, 558 (2012).

14. *See* Emerald Steel Fabricators, Inc. v. Bureau of Labor & Indus., 230 P.3d 518, 536 (Or. 2010).

15. *See* Qualified Patients Ass'n. v. City of Anaheim, 115 Cal. Rptr. 3d 89, 105 (Ct. App. 2010). *See generally* Cole, *supra* note 13, at 558; *see infra* Part VII.

16. U.S. CONST. art. VI, cl. 2 (Supremacy Clause); Wyeth v. Levine, 555 U.S. 555, 584 (2009) (Thomas, J., concurring) ("As long as it is acting within the powers granted it under the Constitution, Congress may impose its will on the States.").

17. *See infra* Part VI (discussing the mixed messages from the federal government regarding enforcement of federal marijuana laws); *see infra* text accompanying notes 261–76 (discussing the Ogden Memorandum).

18. *See infra* Section V.B (discussing the high social costs of prohibition).

19. *See infra* Part VI (discussing state and federal perspectives).

20. *See infra* Part VII (laying out influential case law).

evaluates how much truth there is to the argument that there will soon be an end to federal marijuana prohibition.[21] Although recreational use of marijuana has been recently legalized in Alaska, Colorado, Oregon, Washington, and Washington D.C., the focus of this paper is on the legalization of medical marijuana.[22] Part II traces the origins of medical marijuana.[23] Part III examines U.S. federal law's relationship with international laws regulating marijuana to determine whether the United States may be violating international law if it allows states to legalize marijuana.[24] The chart in Part IV provides an overview of state medical marijuana laws, showing, among other things, what amounts are legally permitted to be carried and the conditions for possession.[25] Part V looks at the rationale the states provide for adopting or prohibiting marijuana laws.[26] Parts VI and VII note the state and federal perspectives as well as the case law shaping the debate.[27] Finally, Part VIII looks at the California Compassionate Use Act to see if it is a standard that is viable and could be emulated in other states.[28]

II. TRACING THE ORIGINS OF MEDICAL MARIJUANA

A The Historical Use and Origins of Medical Marijuana around the World

The use of medical marijuana has deep roots.[29] One can trace its inception back across the millennia to the first written recording

21. Adam O'Neal, *2014: A Banner Year for Legalization of Pot*, REAL CLEAR POLITICS (Jan. 15, 2014), http://www.realclearpolitics.com/articles/2014/01/15/2014_a_banner_year_for_legalization_of_pot__121231.html.

22. *See infra* Part IV (containing chart summarizing medical marijuana laws in the states). Federal law does not distinguish between medicinal and recreational uses of marijuana. Both are forbidden under the CSA. 21 U.S.C. §§ 801–971 (2000).

23. *See infra* Part II (providing the history of medical marijuana).

24. *See infra* Part III (discussing the role of international treaties in the debate over medical marijuana legalization).

25. *See infra* Part IV (containing chart summarizing the status of medical marijuana in the states).

26. *See infra* Part V (examining the pros and cons of prohibition).

27. *See infra* Parts VI–VII.

28. *See infra* Part VIII.

29. *See* ALISON MACK & JANET JOY, MARIJUANA AS MEDICINE: THE SCIENCE BEYOND THE CONTROVERSY 14 (2000).

of marijuana's use in Asia.[30] That is, "the earliest known descriptions of marijuana appear in the ancient writings and folklore of India and China . . . ."[31] Around 2700 BC, "[a]ccording to Chinese legend, Emperor Shen Nung," the Father of Chinese medicine, "discovered marijuana's healing properties as well as those of two other mainstays of Chinese herbal medicine, ginseng and ephedra."[32] Marijuana was listed in Emperor Shen's book of drugs as a treatment for gout, malaria, and gas pain.[33] In 1213 BC, Egyptians began using marijuana to treat glaucoma and inflammation, and to administer enemas.[34] Across the Arabian Sea, *bhang*, a drink of cannabis and milk, was consumed in India as an anesthetic.[35]

In 700 BC, the medical use of marijuana in the Middle East was recorded by the founder of Zoroastrianism, Zoroaster (or Zarathustra), in the *Vendidad*, one of the volumes of the Zend-Avesta, the ancient Persian religious text.[36] The Vendidad borrowed many cultural influences from the Vedas, mentioning *bhang* and listing marijuana as the most important of 10,000 medicinal plants.[37] An earlier, and very central, Indian medical text, the *Ayurvedic*, recommended marijuana as a treatment for leprosy.[38] A little further west, in ancient Greece, "[marijuana] was used to treat earache, edema, and inflammation."[39]

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30. *Id.*

31. *Id.* at 14.

32. *Id.; Classics of Traditional Chinese Medicine from the History of Medicine Division National Library of Medicine*, U.S. NAT'L LIBR. OF MED., https://www.nlm.nih.gov/exhibition/chinesemedicine/emperors.html (last updated Apr. 16, 2012) (providing authority for assertion that Shen was the Father of Chinese medicine); *see also* ROBERT DEITCH, HEMP—AMERICAN HISTORY REVISITED: THE PLANT WITH A DIVIDED HISTORY 9 (2003) ("[Even] [t]he Chinese Emperor Fu Hsi (ca. 2900 BC), whom the Chinese credit with bringing civilization to China, seems to have made reference to *Ma*, the Chinese word for Cannabis, noting that Cannabis was a very popular medicine that possessed both yin and yang.").

33. *See* MACK & JOY, *supra* note 29, at 14; *see also Historical Timeline: History of Marijuana as Medicine—2900 BC to Present*, PROCON.ORG [hereinafter *Historical Timeline*], http://medicalmarijuana.procon.org/view.timeline.php?timelineID=000026 (last updated Aug. 13, 2013).

34. *Historical Timeline*, *supra* note 33.

35. *Id.*

36. *Id.*

37. *Id.*

38. *Id.*

39. *Id.*

Marijuana made its way to the New World when the settlers of Jamestown brought it with them across the Atlantic.[40] Between 1745 and 1775, George Washington, America's first president, made regular recordings in his personal diary concerning his annual hemp production.[41] Similarly, as noted in his farming diaries, Thomas Jefferson grew hemp at Monticello between 1774 and 1824.[42] Although, contrary to modern folklore, there is no evidence to suggest that Jefferson was a habitual smoker of hemp, tobacco, or any other substance.[43]

Around the turn of the nineteenth century, Napoleon's forces brought marijuana from Egypt to France.[44] At the time Napoleon invaded Egypt, an expedition team of scientists accompanied his armed forces.[45] This team brought marijuana back to France in 1799.[46] Once back in Europe, marijuana was tested for its sedative and pain-relieving effects and became widely accepted in Western medicine.[47] French psychiatrist Jacques-Joseph Moreau found in studies in the 1840s that marijuana alleviated headaches and pains, boosted appetites, and was also helpful to people in sleeping.[48]

Medical marijuana was reintroduced to the United Kingdom by William O'Shaughnessy, an army surgeon who introduced other doctors to the healing properties of marijuana.[49] Marijuana was

40. *Id.; see also* BERNARD SEGAL, PERSPECTIVES ON DRUG USE IN THE UNITED STATES 14 (1986) ("The Jamestown settlers brought the marijuana plant, commonly known as hemp, to North America in 1611 . . . . [H]emp fiber was an important export . . . . Indeed, in 1762, 'Virginia awarded bounties for hemp culture and manufacture, and imposed penalties on those who did not produce it.'").

41. *George Washington Grew Hemp*, GEORGE WASHINGTON'S MOUNT VERNON (2015), http://www.mountvernon.org/george-washington/the-man-the-myth/george-washington-grew-hemp.

42. *See Historical Timeline, supra* note 33.

43. THOMAS JEFFERSON, THOMAS JEFFERSON'S FARM BOOK 348 (1824); *see also Thomas Jefferson Papers*, MASS. HISTORICAL SOC'Y (2003), http://www.masshist.org/thomasjeffersonpapers/.

44. *Historical Timeline*, *supra* note 33.

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*

49. *Ninth Report: Cannabis*, HOUSE OF LORDS SELECT COMMITTEE ON SCIENCE AND TECHNOLOGY (1998), http://www.parliament.the-stationery-office.co.uk/pa/ld199798/ldselect/ldsctech/151/15103.htm; SCIENCE AND TECHNOLOGY COMMITTEE, CANNABIS: THE SCIENTIFIC AND MEDICAL EVIDENCE, 1997–98, Parl Deb

then used in the treatment of many conditions, including muscle spasms, headaches, cramps, asthma, diabetes, and acute and chronic pain.[50]

B. Historical Background of the Use and Origins of Medical Marijuana in the United States

Having made its way to Jamestown early in the history of European colonization, by 1850, marijuana had made its way into the United States Pharmacopeia—the official authority for prescription and over-the-counter medicines in early America.[51] Marijuana was listed as a treatment for a plentitude of afflictions, including neuralgia, tetanus, typhus, cholera, rabies, dysentery, alcoholism, opiate addiction, anthrax, leprosy, incontinence, gout, convulsive disorders, tonsillitis, insanity, and even excessive menstrual and uterine bleeding.[52]

In 1906, President Roosevelt signed the Food and Drugs Act, known then simply as the Wiley Act.[53] The Wiley Act regulated product labeling—a change from the then pre-market approach approved by the Federal Drug Agency (FDA).[54] The legislation declared that a drug is misbranded "if the package fails to bear a statement on the label of, among other things, the quantity or proportion of any alcohol, morphine, opium, cocaine, heroin . . . or any [of their] derivative[s]."[55] Ironically, labeling was not an issue when dealing with exports to a foreign country, given that the Act did not specifically apply to products "intended for

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HL (5th ser.) ¶ 2.5 [hereinafter SCIENCE AND TECHNOLOGY COMMITTEE].

50. MACK & JOY, *supra* note 29, at 15–16.

51. *Id.* at 16.

52. *Id.*; *see* SCIENCE AND TECHNOLOGY COMMITTEE, *supra* note 49.

53. Wiley Act, Pub. L. No. 59–384, ch. 3915, § 1, 34 Stat. 768 (1906).

54. *Id.* ("That it shall be unlawful for any person to manufacture within any Territory or the District of Columbia any article of food or drug which is adulterated or misbranded, within the meaning of this Act; and any person who shall violate any of the provisions of this section shall be guilty of a misdemeanor, and for each offense shall, upon conviction thereof, be fined not to exceed five hundred dollars, or shall be sentenced to one year's imprisonment, for each subsequent offense and conviction thereof shall be fined not less than one thousand dollars or sentenced to one year's imprisonment, or both such fine and imprisonment, in the discretion of the court."); *FDA History—Part I*, U.S. FOOD AND DRUG ADMIN., http://www.fda.gov/AboutFDA/WhatWeDo/History/Origin/ucm054819.htm (last updated June 6, 2009).

55. Wiley Act § 8.

export to any foreign country and prepared or packed according to the specifications or directions of the foreign purchaser . . . ."[56] Since labeling was only an issue for products to be used domestically, the mislabeling of marijuana was irrelevant because the plant was not intended for the United States.

The year 1910 ushered in strong feelings against the acceptance of marijuana in America.[57] As a result, states passed laws prohibiting marijuana use. The first state to do so was Utah, which was quickly followed by nine others.[58] Cannabis was also banned throughout the states during the 1910s, as part of a populist afterthought.[59] These states did not pass these laws due to widespread public concern about marijuana. Rather, it was for implementing regulatory initiatives to discourage future use.[60] In order to regulate the domestic manufacturing of opium as well as international trade, Representative Francis B. Harrison (D-NY) introduced three bills, one of which became the Harrison Act.[61] In 1915, President Wilson signed the Harrison Act, which became a model for much of the future drug regulations.[62] The Harrison Act created a system of serial numbers on medications and also required physicians to register with the federal government if they

56. *Id.*

57. Dale H. Gieringer, *The Origins of Cannabis Prohibition in California*, CAL. NORML 1, 25 (Jun. 2006), http://www.canorml.org/background/caloriginsmjproh.pdf.

58. Pete Guither, *Why is Marijuana Illegal?*, DRUGWARRANT.COM, http://www.drugwarrant.com/articles/why-is-marijuana-illegal ("[I]ncluding Wyoming (1915), Texas (1919), Iowa (1923), Nevada (1923), Oregon (1923), Washington (1923), Arkansas (1923), and Nebraska (1927)."). The state of New York outlawed cannabis in 1927. Gieringer, *supra* note 57, at 27, 35 (listing Massachusetts, Maine, Wyoming, Indiana, Utah, and Vermont).

59. Gieringer, *supra* note 57, at 25.

60. *See id.*

61. *Historical Timeline*, *supra* note 33 ("Harrison also proposed that the government 'impose a special tax upon all persons who . . . sell, distribute or give away opium or coca leaves . . . .'"); *see* Dennis Joseph Pfennig, *Early Twentieth Century Responses to the Drug Problem*, 6 OAH MAG. HIST. 2, 26 (1991).

62. Pfennig, *supra* note 61, at 26*; see also Historical Timeline*, *supra* note 33; *Presidential Timeline of Federal Drug Legislation in the United States,* http://www.udel.edu/soc/tammya/pdf/crju369_presidentTimeline.pdf (last visited Mar. 13, 2016).

wished to prescribe opiates.[63] The Act became the basis for the Marijuana Tax Act of 1937.[64]

By the 1930s, American pharmaceutical firms began selling extracts of marijuana as medicines.[65] As demand for marijuana-based medications increased, pharmaceutical firms attempted to produce consistently potent and reliable drugs from marijuana.[66] Congress consolidated the drug control effort in the Federal Bureau of Narcotics under the leadership of its commissioner, Harry Jacob Anslinger.[67] Anslinger became the national voice of prohibition.[68] His case for prohibition rested on the assertion "that the drug caused insanity [and] that it pushed people toward horrendous acts of criminality."[69] As the force of prohibition gained momentum, states begin to enact laws to regulate marijuana at the same time that new drugs such as aspirin, morphine, and other opium-derived medications began to show their effectiveness as painkillers.[70] Consequently, forty-eight states had passed laws regulating marijuana by the end of 1936.[71]

1. The Marijuana Tax Act of 1937

The Marijuana Tax Act of 1937 was precipitated by publicized accounts of marijuana causing madness, inciting users to commit heinous, immoral crimes, as well as the perception that local and

63. *See Historical Timeline*, *supra* note 33.

64. *Id.*

65. MACK & JOY, *supra* note 29, at 17 ("By the 1930s at least two American companies—Parke-Davis and Eli Lily—were selling standardized extracts of marijuana for use as an analgesic, an antispasmodic and sedative. Another manufacturer, Grimault & Company, marketed marijuana cigarettes as a remedy for asthma.").

66. *Id.*

67. Brent Staples, *The Federal Marijuana Ban Is Rooted in Myth and Xenophobia*, N.Y. TIMES (July 29, 2014), http://www.nytimes.com/2014/07/30/opinion/high-time-federal-marijuana-ban-is-rooted-in-myth.html.

68. *Id.*

69. *Id.* Harry J. Anslinger was appointed Commissioner of the Federal Bureau of Narcotics. *See id.* "During 1936 the Bureau headlined the marihuana danger in its report ['Traffic in Opium and Other Dangerous Drugs']. For the first time it urged federal controls and presented a description of the vice, describing dire mental and moral changes among users." Michael Schaller, *The Federal Prohibition of Marihuana*, 4 J. SOC. HIST. 61, 66 (1970).

70. Staples, *supra* note 67.

71. MARK EDDY, MEDICAL MARIJUANA: REVIEW AND ANALYSIS OF FEDERAL AND STATE POLICIES 2 (2010), https://www.fas.org/sgp/crs/misc/RL33211.pdf.

state efforts were failing to resolve the issue of illegal drug use.[72] Under the Marijuana Tax Act, growers, buyers, and sellers of marijuana were not only required to report and register marijuana sales, but were also expected to pay taxes.[73] The unintended consequence of this imposed taxation was that it tended to prohibit marijuana, given that the added taxes would further remove incentives to potential buyers.[74] The Act was the "federal government's first attempt to regulate marijuana."[75] The 1914 Harrison Act "maintained the right to use marijuana for medical purposes;" however, physicians and pharmacists were required to register with federal authorities and pay an annual tax or license fee for prescription or dispensation of marijuana.[76] Consequently, this increased regulation resulted in a sharp drop in the demand for and use of marijuana.[77] In 1942, marijuana lost its official recognition by the government as a legitimate medicine and was removed from the U.S. Pharmacopeia.[78]

"Congress established mandatory minimum prison sentences" for federal drug offenses in 1951 with the passing of the Boggs Act by Representative Hale Boggs (D-La).[79] Under the Boggs Act, first-time offenses were given two to five year minimum sentences, including the offense of possession of marijuana.[80] As a result, the sentencing recommendations failed to distinguish between personal drug use and drug trafficking.[81] Congress included marijuana in the Narcotics Control Act of 1956, which resulted in stricter mandatory sentences for marijuana-related offenses which included raising the bar to make "[a] first-offense marijuana

72. *Id.*

73. *Id.*

74. *Id.*

75. *Id.*

76. Rosalie Liccardo Pacula et al., *State Medical Marijuana Laws: Understanding the Laws and Their Limitations* 3–4 (ImpacTeen Research Paper Series No. 13, 2001), http://www.oregon.gov/pharmacy/Imports/Marijuana/StaffInfo/StateMedicalMarijuanaLawsUnderstandingTheLawsAndTheirLimitations.pdf.

77. *Id.* at 4.

78. *Id.*

79. *Id.*; *Historical Timeline*, *supra* note 33; MOLLY M. GILL, FAMILIES AGAINST MANDATORY MINIMUMS, CORRECTING COURSE: LESSONS FROM THE 1970 REPEAL OF MANDATORY MINIMUMS 2 (2008).

80. *Historical Timeline,* s*upra* note 33.

81. *Id.* The motivation "behind the Boggs Act was the mistaken belief that drug addiction was a contagious and perhaps incurable disease and that addicts should be quarantined and forced to undergo treatment" for public safety. *Id.*

possession carr[y] a minimum sentence of 2–10 years with a fine of up to $20,000."[82]

2. The Controlled Substance Act (CSA)

The 1970 CSA passed by Congress was a part of a comprehensive drug abuse prevention plan.[83] This law was innovative in the United States, as it created and also incorporated a management system for narcotic and psychotropic drugs.[84] The CSA was employed by Congress to control and regulate trade in, and the use of, such substances, as well as to satisfy the obligations of the United States under the Single Convention on Narcotic Drugs of 1961 and the subsequent Convention on Psychotropic Drugs of 1971.[85] The CSA governs all aspects of the handling, production, sale, and use of various covered substances.[86] The CSA created a five-tier system of schedules to classify substances.[87] Marijuana was placed in Schedule I, which are drugs "classified as having a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use of the drug or other substances under medical supervision."[88]

When considering the placement of marijuana in the five-tier system, Congress asked the Department of Health, Education, and Welfare for its recommendation.[89] The response, by letter dated August 14, 1970, of Roger O. Egeberg, the Assistant Secretary for Health and Scientific Affairs, reads as follows:

> Some question has been raised whether the use of the plant itself produces 'severe psychological or physical dependence' as required by a schedule I or even schedule II criterion. Since there is still a considerable void in our knowledge of the plant and effects of the active drug

82. *Busted: America's War on Marijuana*, PBS: FRONTLINE, http://www.pbs.org/wgbh/pages/frontline/shows/dope/etc/cron.html (last visited Mar 13, 2016).

83. *Historical Timeline*, *supra* note 33.

84. *Id.*

85. 21 U.S.C. § 801(a); Sabet, *supra* note 5, at 84 ("As a signatory to these treatises, the U.S. is required by federal legislation to establish a range of requirements and prohibitions seeking to ensure that all psychoactive substances are used purely for legitimate medical and scientific purposes.").

86. Sabet, *supra* note 5, at 84.

87. *Id.* at 85–87.

88. *Historical Timeline*, *supra* note 33.

89. *Id.*

> contained in it, our recommendation is that marihuana be retained within schedule I at least until the completion of certain studies now underway to resolve the issue. If those studies make it appropriate for the Attorney General to change the placement of marijuana to a different schedule, he may do so in accordance with the authority provided under section 201 of the bill.[90]

This shows that the quest for the reclassification of marijuana has been ongoing for over thirty years and the position still upheld by Congress today is probably buttressed by support from its historical stance of opposition to reclassification.

In 1970, a presidential commission (later known as the Shafer Commission) was responsible for examining marijuana policy.[91] In 1971, the Shafer Commission recommended rescheduling marijuana.[92] However, the president rejected their recommendation.[93] In fact, prior to the Commission's completion of its work, President Richard Nixon stated in a televised news conference on May 1, 1971:

> As you know, there is a Commission that is supposed to make recommendations to me about this subject. In this instance, however, I have such strong views that I will express them. I am against legalizing marijuana. Even if the Commission does recommend that it be legalized, I will not follow that recommendation . . . I can see no social or moral justification whatever for legalizing marijuana. I think it would be exactly the wrong step. It would simply encourage more and more of our young people to start down the long, dismal road that leads to hard drugs and eventually self-destruction.[94]

As President Nixon had warned, he rejected the bipartisan Shafer Commission's recommendation that the personal use of marijuana be decriminalized.[95]

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90. JON GETTMAN, THE 1995 MARIJUANA RESCHEDULING PETITION 224 (1995) (citing Letter from Roger O. Egeberg to Harley O. Staggers (Aug. 14, 1970)). These studies resulted in the 1972 Schafer Commission report, which recommended removing marijuana from the scheduling system and decriminalizing it. *Id.*

91. *Historical Timeline*, *supra* note 33.

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.* However, over the course of the 1970s, eleven states decriminalized marijuana and most others reduced their penalties. *See Busted*, *supra* note 82.

3. Drug Enforcement Agency (DEA)

Prior to the creation of the Drug Enforcement Agency (DEA), drug enforcement rested in the hands of two federal offices: the Bureau of Narcotics, located within the Treasury Department, and the Bureau of Drug Abuse Control.[96] The Bureau of Narcotics was responsible for the control of marijuana and narcotics, such as heroin.[97] By 1968, the recreational use of illegal drugs was becoming commonplace.[98] In response to the steady rise in substance abuse, President Lyndon Johnson facilitated a restructuring of federal agencies that resulted in the Bureau of Narcotics and the Bureau of Drug Abuse Control merging under a single umbrella agency called the Bureau of Narcotics and Dangerous Drugs, located under the purview of the Department of Justice.[99] Under the auspices of President Nixon, the Bureau of Narcotics and Dangerous Drugs and the Office of Drug Abuse Law Enforcement were merged to form the DEA as the single federal agency for drug control.[100] President Nixon acted to end interagency rivalries, thereby maximizing the efficiency of the Justice Department and further focusing federal law enforcement operations on the drug trade.[101]

4. The National Organization for the Reform of Marijuana Laws (NORML): Attempts to Reclassify Marijuana

The National Organization for the Reform of Marijuana Laws (NORML), whose primary mission is to end marijuana prohibition, was founded in 1970 to give a voice to those Americans who opposed marijuana prohibition.[102] In the decade after its founding, NORML led successful efforts to decriminalize minor marijuana offenses in eleven states and greatly reduce penalties in others.[103] On May 18, 1972, NORML filed an administrative petition with the

96. *U.S. Drug Enforcement Administration (DEA)*, ALLGOV, http://www.allgov.com/departments/department-of-justice/us-drug-enforcement-administration-dea?agencyid=7195 (last visited Mar. 13, 2016).

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. *Introduction*, NORML, http://norml.org/about/intro (last visited Mar. 13, 2016).

103. *Id.*

DEA asking the federal government to reclassify marijuana under the Controlled Substances Act as a Schedule V drug.[104] However, the federal authorities at the DEA refused to accept the petition until obliged to do so by a U.S. Court of Appeals in 1974.[105] Eventually, in 1988, administrative law Judge Francis Young ruled that the therapeutic use of marijuana was recognized by a respected minority of the medical community and that marijuana met the standards of other legal medications.[106] In any event, on December 30, 1989, DEA Administrator Jack Lawn overruled the decision of the administrative law judge, and reiterated that marijuana should remain a Schedule I controlled substance.[107] In 1994, a final decision in this over twenty-five year battle was rendered by the U.S. Court of Appeals, upholding that marijuana be maintained in Schedule I.[108] Today, NORML continues to attempt to reform state and federal marijuana laws through voter initiatives and legislation.[109]

104. Nat'l Org. for Reform of Marijuana Laws (NORML) v. Ingersoll, 497 F.2d 654, 655–56 (D.C. Cir. 1974).

105. *Id.* at 660 (holding that the rulemaking petition must be remanded to the Director of the DEA).

106. Marijuana Rescheduling Petition, No. 86-22, 65 (U.S. Dep't of Justice, Drug Enforcement Admin. Sept. 6, 1988), http://www.oregon.gov/pharmacy/Imports/Marijuana/Public/SRay/CourtDocket86-22.pdf (opinion and recommendation of administrative law judge). Young suggested that marijuana be rescheduled from Schedule I to Schedule II for nausea associated with cancer chemotherapy. *Id.* at 33. He also concluded that the evidence was insufficient to warrant the use of marijuana for glaucoma. *Id.* at 37.

107. DRUG ENFORCEMENT ADMINISTRATION: A TRADITION OF EXCELLENCE: 1973–2008, at 68 (2008). ("DEA Administrator Jack Lawn overruled the decision of one administrative law judge who had agreed with marijuana advocates that marijuana should be moved from Schedule I . . . . Lawn maintained that there was no medicinal benefit to smoking marijuana . . . . Lawn maintained that marijuana should remain a Schedule I controlled substance."); Marijuana Scheduling, 54 Fed. Reg. 53,767 (U.S. Dep't of Justice, Drug Enforcement Admin. Dec. 29, 1989) (denial of petition).

108. *25 Years Ago: DEA's Own Administrative Law Judge Ruled Cannabis Should Be Reclassified under Federal Law*, NORML (Sept. 3, 2013), http://norml.org/news/2013/09/05/25-years-ago-dea-s-own-administrative-law-judge-ruled-cannabis-should-be-reclassified-under-federal-law.

109. *Introduction*, NORML, *supra* note 102.

5. National Institute on Drug Abuse (NIDA)

The National Institute on Drug Abuse (NIDA) is the exclusive entity responsible for reporting data on marijuana in the United States.[110] As a result, NIDA is authorized to issue contracts to grow marijuana for research.[111] Because the United States is a signatory to the 1961 Single Convention treaty agreement which prohibits the production, trade, and possession of marijuana for non-medical purposes, and makes those activities punishable offenses under domestic law, the United States does run the risk of contravening the tenets of the Convention by legalizing marijuana.[112] The Single Convention on Narcotics of 1961 mandated federal control of the production of any marijuana for scientific research, thereby rendering recreational marijuana a violation of the treaty and international law.[113] Consequently, the treaty requires that governments (in this case, the federal government) create a single agency to monitor, regulate, and safeguard all of the national production of marijuana for research.[114] NIDA became that agency.[115]

Since 1968, the University of Mississippi has held a registration from NIDA and its predecessor agency to grow marijuana for government-approved research and has been the only legal source of marijuana in the United States for government-approved marijuana research under the direct guidance of the NIDA.[116]

110. Nat'l Advisory Council on Drug Abuse, *Provision of Marijuana and Other Compounds For Scientific Research—Recommendations of the National Institute on Drug Abuse National Advisory Council*, NAT'L INST. ON DRUG ABUSE (1988), http://archives.drugabuse.gov/about/organization/nacda/MarijuanaStatement.html [hereinafter *Recommendations of NIDA*] (last visited Mar. 13, 2016).

111. *Id.*

112. Single Convention on Narcotic Drugs of1961 art. 36, Mar. 30, 1961, 18 U.S.T. 1407, 976 U.N.T.S. 105; *see* Matt J. Stannard, Case Note, *Criminal Law—A Canonical Conundrum Concerning Cannabis: How Wyoming's Supreme Court Ignored Its Own Interpretative Rules and Read a Medical Marijuana Defense out of the Law,* Burns v. State, *246 P.3d 283 (Wyo. 2011),* 12 WYO. L. REV. 453, 457 (2012).

113. *See* Single Convention on Narcotic Drugs of 1961, *supra* note 112, at art. 2, ¶ 5.

114. *See Historical Timeline*, *supra* note 33 (describing events of 1974).

115. *See NIDA's Role in Providing Marijuana for Research*, NAT'L INST. ON DRUG ABUSE, http://www.drugabuse.gov/drugs-abuse/marijuana/nidas-role-in-providing-marijuana-research (last visited Mar. 13, 2016).

116. *See Recommendations of NIDA*, *supra* note 110.

III. THE UNITED STATES' RELATIONSHIP WITH THE INTERNATIONAL LAWS REGULATING MARIJUANA

In February of 1925, the League of Nations signed the International Opium Convention, a multilateral treaty restricting marijuana use to scientific and medical purposes for the first time.[117] Egypt proposed that hashish (marijuana resin) be added to the list of compounds to be controlled by the convention.[118] The convention authorized the production, use, or sale of cannabis only for state-approved scientific or medical purposes.[119] Consequently, restrictions on importing and exporting cannabis resin were put into place.[120]

While there were several international conventions addressing drugs,[121] the most influential international treaty on U.S. federal policy was the Single Convention on Narcotic Drugs. Adopted in 1961, the terms of the treaty provide a framework for modern U.S. policy and require participating countries to adopt measures to prevent the misuse and illicit trafficking of marijuana.[122] Congress approved participation in the convention in 1967 and three years later passed the Comprehensive Drug Abuse Prevention and Control Act,[123] "which provides the basis for current federal prohibitions regarding marijuana use."[124] The primary purpose of the treaty was to regulate selected drugs for use exclusively for

117. *See* UNITED NATIONS OFFICE ON DRUGS AND CRIME, THE CANNABIS PROBLEM: A NOTE ON THE PROBLEM AND THE HISTORY OF INTERNATIONAL ACTION (Jan. 1, 1962), https://www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1962-01-01_4_page005.html.

118. *Id.*

119. *See* MARTIN JELSMA, GLOBAL COMM'N ON DRUG POLICIES, THE DEVELOPMENT OF INTERNATIONAL DRUG CONTROL: LESSONS LEARNED AND STRATEGIC CHALLENGES FOR THE FUTURE 2–3 (Jan. 2011), http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_Martin_Jelsma.pdf./Global_Com_Martin_Jelsma.pdf.

120. *Id.*

121. *See* UNITED NATIONS OFFICE ON DRUGS AND CRIME, 2008 WORLD DRUG REPORT 21 (2008), https://www.unodc.org/documents/wdr/WDR_2008/WDR_2008_eng_web.pdf.

122. *See* NAT'L RESEARCH COUNCIL, COMM. ON SUBSTANCE ABUSE AND HABITUAL BEHAVIOR, AN ANALYSIS OF MARIJUANA POLICY 2 (1982); Allison E. Don, *Lighten Up: Amending the Single Convention on Narcotic Drugs*, 23 MINN. J. INT'L L. 213, 224–25 (2014).

123. Pub. L. No. 91-513, 84 Stat. 1236 (1970).

124. *See* NAT'L RESEARCH COUNCIL, *supra* note 122, at 2.

medical and scientific purposes.[125] Under the Convention, drugs are divided into four Schedules, with cannabis in both Schedules I and IV.[126] Schedules I and IV of the Convention encompass the most dangerous drugs, and this buttresses the fact that marijuana is considered "particularly liable to abuse and to produce ill effects [which] is not offset by any substantial therapeutic advantages."[127] The Convention also provides guidelines for punishment, suggesting that signatory countries implement corresponding punishment and recommending imprisonment for serious violations.[128] The compliance of member states under the Convention is monitored by the International Narcotics Control Board (the Board)[129] and the Commission on Narcotic Drugs of the Economic and Social Council (the Commission)[130] as created respectively.[131]

Not surprisingly, the Board, as a party to the Convention, was especially interested in the United States, and in the progression towards the legalization of marijuana at the state level, particularly in Washington and Colorado.[132] Consequently, in 2013, the President of the Board reiterated that "the 1961 Convention limits the licit use of narcotic drugs—including [marijuana]—to medical and scientific purposes."[133] He also stated, "[T]he 1961 Convention . . . needs to be implemented worldwide, on the national but also on the sub-national level."[134] The Board requested that the U.S. government, "take effective measures to ensure the implementation of all control measures for cannabis plants and

125. *See* Don, *supra* note 122, at 224 (citing Single Convention on Narcotic Drugs of 1961, *supra* note 112, at pmbl).

126. *Id.*

127. *Id.*

128. Single Convention on Narcotic Drugs of 1961, *supra* note 112, at art. 36(1)(a).

129. *See* Don, *supra* note 122, at 225 ("The Single Convention provides the Board with specific powers in order to secure compliance should the Single Convention's goals become threatened.").

130. *Id.* ("The Commission is entrusted with maintaining the Single Convention, including amending the Schedules and providing recommendations for scientific research.").

131. *Id.*

132. Don, *supra* note 122, at 226. These states approved the use of marijuana for recreational purposes despite conflicting federal law. *Id.* at 214.

133. *Id.* (quoting RAYMOND YANS, REP. OF THE INT'L NARCOTICS CONTROL BOARD 7 (2013)).

134. *Id.*

cannabis, as required under the 1961 Convention, in all states and territories falling within its legislative authority."[135] Consequently, by publishing the Deputy Attorney General's memo—reassuring the states that as long as they enacted a strong regulatory system to oversee the distribution of marijuana, the federal government will not become involved—the United States was publicly undermining the Board's authority by ignoring the guidance that had been issued a few months prior.[136] The force of the Single Convention treaty is unquestionably impacting marijuana legalization in the United States,[137] although the states may be doing so without taking the Convention into consideration. The United States' tolerance of states legalizing marijuana production and use is illustrative of the hypocrisy in its international treaty obligations.[138] In the same vein, it is in conflict with the United States' current practice of withholding aid from Mexico and Colombia as a punitive measure in response to their ineffective efforts against drug trafficking.[139]

In the international arena, the United States is not the only country leading marijuana legalization. Uruguay passed a marijuana legalization bill—signed into law on December 23, 2013—making it "the first in the world to legalize, regulate and tax the drug."[140] In a similar vein, in the mid-1970s, the Netherlands, hoping to decrease the use of heroin, decriminalized the use of marijuana.[141] The Netherlands is a member of the Single Convention, and, despite its recognition that marijuana is an "illegal substance," it does not prosecute users of the drug.[142] Additionally, the country allows for the presence of "coffee shops,"

135. *Id.* at 226–27 (citation omitted).

136. *Id.* at 227; *see* Memorandum from David Ogden, Deputy Att'y Gen., U.S. Dept. of Justice, to Selected U.S. Attorneys (Oct. 19, 2009) [hereinafter Ogden Memo], http://www.justice.gov/opa/documents/medical-marijuana.pdf.

137. *See* Melanie Reid, *The Quagmire that Nobody in the Federal Government Wants to Talk About: Marijuana*, 44 N.M. L. REV. 169, 186–87 (2014).

138. *Id.* at 187; *see* Press Release, U.N. Info. Serv., INCB President Calls on the U.S. Gov't to Address Initiatives Aimed at Permitting Recreational Drug Use, U.N. Press Release UNIS/NAR/1164 (Mar. 14, 2013).

139. Reid, *supra* note 137, at 186 (citation omitted).

140. *See* Steven Nelson, *Uruguay's President Quietly Signs Marijuana Legalization Bill*, U.S. NEWS & WORLD REP. (Dec. 26, 2013, 2:41 PM), http://www.usnews.com/news/articles/2013/12/26/uruguays-president-quietly-signs-marijuana-legalization-bill.

141. Don, *supra* note 122, at 229.

142. *Id.* (citation omitted).

in which marijuana is sold.[143] If these shops follow the established rules related to marijuana, law enforcement allow them to operate.[144]

The international community is showing a gradual shift towards support for recreational marijuana, but the issue is whether this rises to the level that would warrant an amendment to the Single Convention to allow member states to legislate on recreational marijuana without constraints from international obligations.[145]

IV. AN OVERVIEW OF STATE MEDICAL MARIJUANA LAWS

The table below provides a simplistic overview of the states that have laws allowing and regulating medical marijuana use, and is current as of June 8, 2015.[146] This table includes those jurisdictions permitting only limited access programs.[147] This table also includes statutory references for those provisions, which allow medical marijuana in those "[thirty-eight] states and the District of Columbia that have passed or enacted some form of medical

143. *Id.* at 230.

144. *Id.* By purchasing their marijuana from "coffee shops," users can get the drug safely, instead of having to risk receiving dangerous drugs from dealers on the street. *Id.*

145. *Id.* at 243.

146. Jalayne J. Arias et al., *Medical Marijuana Summary of Programs and Limited Access Laws*, THE NETWORK FOR PUB. HEALTH L. (June 8, 2015), https://www.networkforphl.org/_asset/sbth8b/State-Medical-Marijuana-Law-Table.pdf. The states marked with an asterisk indicate states that have "only Limited Access Marijuana Product Laws." *Id.* The table shown is a condensed version of that created by The Network for Public Health, a collaboration between the Robert Wood Johnson Foundation and the Public Health Law Center at Mitchell Hamline School of Law. *Id.* The headings of the table are as follows: A "[s]pecifies the entity responsible for administration of the specific state's medical marijuana program;" B "[lists] legal provisions authorizing the use of marijuana for medical purposes in the jurisdiction"; C specifies "provisions in 15 states permitting medical use of Cannabis products with low to zero THC and high CBD concentrations"; D "indicates if the legal authority provides for the operation of dispensaries to distribute medical marijuana; 23 jurisdictions allow dispensaries at this time;" E lists "the 24 jurisdictions with broad programs for patients to obtain and use marijuana for medical purposes;"; and F "indicates if the legal authority provides for the operation of dispensaries to distribute medical marijuana; 23 jurisdictions allow dispensaries at this time." *Id.*

147. *Id.*

marijuana legislation."[148] Colorado and Washington were the first states to legalize the recreational use of medical marijuana.[149]

148. *Id.*

149. *See* COLO. CONST. art. XVIII, § 16; WASH. REV. CODE ANN. § 69.50.325 (West 2015).

MEDICAL MARIJUANA LAWS BY STATE						
State	**A.**	**B.**	**C.**	**D.**	**E.**	**F.**
AL*	Univ. of Alabama-Birmingham, Dep't of Neurology	S.B. 174, 2014 Reg. Sess. (Ala. 2014)	Yes, low THC for debilitating epileptic conditions	No, only Univ. Alabama-Birmingham is allowed to dispense	No	No
AK	Dep't of Health & Social Servs., Bureau of Vital Statistics Marijuana Registry	Alaska Stat. §§ 17.37.010–.080 (2013)	No	No	Yes	Yes
AZ	Dep't of Health Servs., Med. Marijuana Program	Ariz. Rev. Stat. §§ 36-2801–2819 (2013)	No	Yes	Yes	Yes
CA	Dept. of Pub. Health, Med. Marijuana Program	Cal. Health & Safety Code §§ 11362.5, 11362.7–11362.83 (2012)	No	Yes, licensed through local or county ordinances (subject to State Attorney Gen. Off. Guidelines)	Yes	Yes
CO	Dep't of Pub. Health & Environment, Med. Marijuana Registry	Colo. Rev. Stat. §§ 12-43.3, 18-18-406.3, 25-1.5-106 (2013)	No	Yes, provides for center licenses	Yes	Yes

State	A.	B.	C.	D.	E.	F.
CT	Dep't of Consumer Protection, Med. Marijuana Program	CONN. GEN. STAT. §§ 21a-408–408q (2013)	No	Yes	Yes	Yes
DE	Dep't of Health & Soc. Servs., Div. of Pub. Health, Med. Marijuana Program	Del. Code tit. 16, §§ 4901A–4926A (2014)	No	Yes, limited distribution by licensed non-profits	Yes	Yes
DC	Dep't of Health, Med. Marijuana Program	D.C. Code §§ 7-1671.01–.13 (2013); D.C. Mun. Regs. Tit. 22-C, §§ 100-9900 (2014)	No	Yes	Yes	Yes
FL*	Dep't of Health	S.B. 1030, 2014 Reg. Sess. (Fla. 2014)	Yes, low THC and high CBD for cancer and seizure disorders with symptoms controllable by low THC products	Yes, 5 across the state by region	No	Yes

A. Organization & Program Name
B. Legal Authority
C. Restricted to Low or Zero THC/High CBD
D. Allow Dispensaries
E. Broad Medical Marijuana Program
F. Patient Registry

State	A.	B.	C.	D.	E.	F.
GA*	Dep't of Pub. Health	H.B. 1, 2015 Reg. Sess (Ga. 2015)	Yes, low THC and at least equal CBD for cancer, epilepsy, and several other severe conditions	No, only Univ. System of GA can develop THC oil in compliance with FDA trial regulations	No	Yes
HI	Dep't of Pub. Safety, Narcotics Enforcement Div.	Haw. Rev. Stat. §§ 329.121–329.128 (2010)	No	No	Yes	Yes
IL	Dep't of Pub. Health, Div. of Med. Cannabis	H.B. 0001, 98th Gen. Assemb., Reg. Sess. (ILL. 2013); Compassionate Use of Medical Cannabis Patient Registry, 38 Ill. Reg. 16 (Proposed Apr. 18, 2014) (to be codified at Ill. Admin. Code tit. 77, § 946)	No	Yes	Yes	Yes
IA*	Dep't of Pub. Health	Iowa Code §124D.3 (2014)	Yes, low TCH for intractable epilepsy	No in-state access or production mechanism provided	No	Yes

State	A.	B.	C.	D.	E.	F.
KY*	TBD	K.R.S. § 218A.010(21) (2014)	Yes, cannabidiol only	No, only universities in Kentucky with medical schools, or FDA approved clinical trials	No	No
ME	Dep't of Health & Hum. Servs., Div. of Licensing & Regulatory Servs., Maine Med. Use of Marijuana Program (MMMP)	Me. Rev. Stat. Ann. Tit. 22, §§ 2421–2430-B (2011); 10-144-122 Me. Code R. §§ 1–11 (2013)	No	Yes, dispensaries are registered and certified	Yes	Yes
MD	Dep't of Health & Mental Hygiene, Natalie N. LaPrade Med. Marijuana Commission	Md. Code Ann., Crim. Law §§ 5-601(C), 5-619(c) (2014); H.B. 1101, 2013 Reg. Sess. (Md. 2013) (to be codified at Md. Code, Health–Gen. § 10.62)	No	Yes	Yes	Yes

A. Organization & Program Name
B. Legal Authority
C. Restricted to Low or Zero THC/High CBD
D. Allow Dispensaries
E. Broad Medical Marijuana Program
F. Patient Registry

State	A.	B.	C.	D.	E.	F.
MA	Health & Hum. Servs., Div. of Pub. Health, Med. Use of Marijuana	2012 Mass. Acts 369; 105 Mass. Code Regs. 725.001–.800 (2014)	No	Yes	Yes	Yes
MI	Dep't of Licensing & Regulatory Affairs, Michigan Med. Marihuana Program (MMMP)	Mich. Comp. Laws §§ 333.26421–.26430 (2013)	No	No	Yes	Yes
MN	Dep't of Health, Med. Cannabis	2014 Minn. Laws 311	No	Yes, limited to liquid extract products only	Yes	Yes
MS*	Univ. of Miss. Medical Center	H.B. 1231, 2014 Reg. Sess. (Miss. 2014)	Yes, low THC and high CBD for debilitating epileptic conditions	No, only dispensed by the Dep't of Pharmacy Servs. at the Univ. of Miss. Medical Center	No	No
MO*	Dept. of Health & Hum. Servs.	H.B. 2238 Reg. Sess. (Mo. 2014)	Yes, low THC and high CBD for intractable epilepsy	Yes, creates care centers and cultivation facilities	No	No
MT	Dep't of Heath & Hum. Servs., Licensure Bureau, Med. Marijuana Program	Mont. Code Ann. §§ 50-46-301–344 (2013); S.B. 423, 62nd Leg., Reg. Sess. (Mont. 2011)	No	No, but caregivers may serve an unlimited number of patients	Yes	Yes

State	A.	B.	C.	D.	E.	F.
NV	Dep't of Health & Hum. Servs., Div. of Pub. & Behavioral Health, Med. Marijuana Program	Nev. Rev. Stat. §§ 453A.010–.170 (2014)	No	Yes	Yes	Yes
NH	Dep't of Health & Hum. Servs., Therapeutic Use of Cannabis Program	N.H. Rev. Stat. ANN. §§ 126-X:1–11 (2013)	No	Yes	Yes	Yes
NJ	Dep't of Health, Med. Marijuana Program	N.J. Stat. Ann. §§ 24:6I-1–16 (2013); N.J. Admin. Code § 8:64 (2011)	No	Yes, state issued permits for alternative treatment centers	Yes	Yes
NM	Dep't of Health, Med. Cannabis Program	N.M. Stat. Ann. §§ 26-2B-1–7 (2013)	No	Yes, producers are licensed by the state	Yes	Yes

A. Organization & Program Name
B. Legal Authority
C. Restricted to Low or Zero THC/High CBD
D. Allow Dispensaries
E. Broad Medical Marijuana Program
F. Patient Registry

State	A.	B.	C.	C.	D.	E.
NC*	Dep't Health & Hum. Servs.	H.B. 1220, 2014 Reg. Sess. (N.C. 2014)	Yes, low THC and high CBD for intractable epilepsy	No, university research only	No	Yes
NY	Dep't of Health, N.Y State Med. Marijuana Program	H.B. A6357, 2014 Assemb., Reg. Sess. (N.Y. 2014)	No	Yes	Yes	Yes
OK*	TBD	H.B. 2154, 2015 Reg. Sess. (Okla. 2015)	Yes, low THC and high CBD for severe forms of epilepsy	No in-state access or production mechanism provided	No	Yes
OR	Dep't of Hum. Servs., Med. Marijuana Dispensary Program	Or. Rev. Stat. §§ 333-008-0010–1280 (2014)	No	Yes	Yes	Yes
RI	Dep't of Health, Off. of Health Profs. Reg., Med. Marijuana Program	R.I. Gen. Laws §§ 21-28.6-1–13 (2010)	No	Yes, the state registers and certifies Compassion Centers	Yes	Yes
SC*	Dep't Health & Environmental Cont'l	S.B. 1035, 2014 Gen. Assemb., Reg. Sess. (S.C. 2014)	Yes, low TCH and high CBD for severe forms of epilepsy	Yes, CBD product must come from an approved source	No	Yes

State	A.	B.	C.	D.	E.	F.
TN*	Tennessee Tech Univ.	Tenn. Code Ann. § 39-17-402(16) (2014)	Yes, low THC for intractable epilepsy	No, only products produced by Tennessee Tech Univ. are allowed	No	Yes
TX*	Dep't Pub. Safety	S.B. 339, 2015 Reg. Sess (Tex. 2015)	Yes, low THC for intractable epilepsy	Yes, as licensed by the Dep't Pub. Safety	No	Yes
UT*	Utah Dep't Health	H.B. 105, 2014 Gen. Sess. (Utah 2014)	Yes, low THC and high CBD for intractable epilepsy	No, only allows higher education institution to grow or cultivate industrial hemp	No	Yes

A. Organization & Program Name
B. Legal Authority
C. Restricted to Low or Zero THC/High CBD
D. Allow Dispensaries
E. Broad Medical Marijuana Program
F. Patient Registry

State	A.	B.	C.	D.	E.	F.
VT	Dep't of Pub. Safety, Div. of Crim. Just. Servs., Marijuana Registry	Vt. Stat. Ann. tit. 18, §§ 4471-4474l (2011); S.B. 17, 2011 Gen. Assemb., Reg. Sess. (Vt. 2011)	No	Yes	Yes	Yes
VA*	TBD	H.B. 1445, 2015 Reg. Sess. (Va. 2015)	THC/CBD levels not defined, but may not produce	No in-state access or production mechanism provided	No	No
WA	Dep't of Health, Med. Marijuana (Cannabis)	Wash. Rev. Code §§ 69.51A.005–.903 (2013)	No	Yes	No	Yes
WI*	TBD	Assemb. B. 726, 2013 Reg. Sess. (Wis. 2013)	Yes, CBD only for seizure disorders	No in-state access or production mechanism provided	Yes	No

A. Organization & Program Name
B. Legal Authority
C. Restricted to Low or Zero THC/High CBD
D. Allow Dispensaries
E. Broad Medical Marijuana Program
F. Patient Registry

As can be seen in the table, the emerging trend in many states allowing marijuana use is also allowing for the medium of dispensation; consequently, states are incorporating policies regulating dispensaries.[150] For example, unlike California and Colorado, which formally had their dispensaries regulated by state laws, in Washington and Michigan, dispensaries are just only beginning to emerge along with the need for policies to regulate them.[151]

Dispensaries are subject to a wide range of regulations, which vary across the many jurisdictions that have confronted this issue. Some states, like Oregon, have created restrictions against charging for labor beyond the materials and utilities used, and others, like New Mexico, require any grower operations to be conducted in the form of a non-profit and prohibit price discounts for purchasing large volumes.[152] In some states, "[t]he compensation that dispensaries may receive for providing marijuana . . . [to] some the number of patients the dispensary may [entertain]" is regulated or restricted as well.[153] For example, California requires patients to form cooperatives and limits the dispersion of marijuana by the cooperatives to members of the cooperatives.[154] Some "local communities have imposed zoning and licensing requirements on marijuana dispensaries," while others seek to ban them completely.[155]

V. THE RATIONALE FOR MEDICAL MARIJUANA: ADOPTION OR PROHIBITION?

The legalization debate rages on between those advocating for legalization of medical marijuana and those who are opposed to it. Only twenty-two percent of Americans thought marijuana should be legal in 1991.[156] That figure rose to forty-three percent by 2008

150. Rosalie Liccardo Pacula et al., *Assessing the Effects of Medical Marijuana Laws on Marijuana and Alcohol Use: The Devil Is in the Details* 6–7 (Nat'l Bureau of Econ. Research, Working Paper 19302, 2013).

151. *Id.*

152. OR. REV. STAT. ANN. § 475.420(8) (Westlaw through Ch. 12 of 2016 Reg. Sess.).

153. Robert A. Mikos, *A Critical Appraisal of the Department of Justice's New Approach to Medical Marijuana*, 22 STAN. L. & POLY. REV. 633, 636 (2011).

154. *Id.* at 636–37.

155. *Id.* at 637.

156. Juliet Lapidos, *The Public Lightens Up about Weed*, N.Y. TIMES, July 26, 2014,

according to the Pew Research Center.[157] According to a 2013 survey by the Pew Research Center, three out of four Americans believe marijuana has legitimate medical uses and that people with serious illnesses should have safe and legal access to it.[158] What could be the rationale for this change in view? Looking at some of the reasons and rationale advanced for finding in favor of legalization may highlight the current trend towards acceptance of marijuana presently seen in the country.[159]

A. Medical Marijuana is Proven to be Effective in the Treatment of a Variety of Debilitating Medical Conditions

Public opinion on medical marijuana has shifted dramatically in the last two decades:[160] twenty-three states and Washington, D.C., have adopted laws that allow people with certain medical conditions to use medical marijuana, and similar laws are being considered in states around the country.[161] Many conservative states have attempted to preempt abuse of medical marijuana by passing laws permitting epilepsy patients to use strains of cannabis high in CBD.[162] Again, as stated previously, the federal government still lists cannabis as a Schedule I drug and therefore still does not acknowledge any legitimate medical use.[163] However, most states clearly disagree, as shown by the increase in state legislation

at SR10.

157. *Id.*

158. MICHAEL DIMOCK, CARROLL DOHERTY & SETH MOTEL, PEW RESEARCH CTR., MAJORITY NOW SUPPORTS LEGALIZING MARIJUANA 6 (2013), http://www.people-press.org/2013/04/04/majority-now-supports-legalizing-marijuana/.

159. *See infra* Part V (arguing for legalization of marijuana).

160. Lapidos, *supra* note 156, at SR10.

161. Editorial Board, *Repeal Prohibition, Again*, N.Y. TIMES (July 27, 2014), http://www.nytimes.com/interactive/2014/07/27/opinion/sunday/high-time-marijuana-legalization.html?_r=0; Therese A. Clarke Arado & Annie Mentkowski, *Medical Marijuana: An Overview of Select Resources*, 35 N. ILL. U. L. REV. 461, 462–81 (2015) (providing an overview of state laws concerning the legalization of medical marijuana).

162. Editorial Board, *supra* note 161. *The New York Times* lists epilepsy, along with pain from AIDS and nausea from chemotherapy, as afflictions that cannabis has been shown to alleviate. Added to this list is glaucoma, Crohn's disease, muscle spasms related to multiple sclerosis, and a host of other conditions marijuana has effectively treated. *Id.*

163. Aurit, *supra* note 3, at 549.

embracing medical marijuana.[164] In the last two decades, there has been a dramatic increase in the number of states with some form of medical marijuana law.[165] In spite of this, marijuana is still legally risky to use for those millions of people who would benefit from use.[166] Relaxing medical marijuana laws would be an aid to many patients but prohibition would inflict great harm to those who would find it helpful.[167] "People who would benefit from medical marijuana should not have to wait—and in some cases cannot wait—for the right to use it legally."[168] Studies have demonstrated that use of medical marijuana is safe and effective for people suffering from a variety of debilitating medical conditions.[169] For example, a University of California study published in February 2007 found that "marijuana relieves neuropathic pain (pain caused by damage to nerves), a symptom commonly associated with multiple sclerosis, HIV/AIDS, diabetes, and a variety of other conditions for which conventional pain drugs are notoriously inadequate—and it did so with only minor side effects."[170]

Physicians show strong support for the use of medical marijuana.[171] In 2005, a national survey was carried out by HCD Research and the Muhlenberg College Institute of Public Opinion.[172] Of those doctors surveyed, 73 percent were in favor of the use of "marijuana to treat nausea, pain, and other symptoms associated with AIDS, cancer, and glaucoma."[173] Among those doctors, 56 percent said they were willing to recommend medical

164. *Id.*

165. *Id.* at 552.

166. *Id.*

167. Editorial Board, *supra* note 161.

168. Effective Arguments for Medical Marijuana Advocates, MARIJUANA POLICY PROJECT (July 7, 2014) [hereinafter Effective Arguments], https://www.mpp.org/issues/medical-marijuana/effective-arguments-for-medical-marijuana/ (last visited Mar. 13, 2016).

169. *Id.* at 2.

170. *Id.* (citing D. Abrams et al., *Cannabis in Painful HIV-Associated Sensory Neuropathy: A Randomized Placebo-Controlled Trial*, 68 NEUROLOGY 515 (2007)); R.J. Ellis et al., *Smoked Medicinal Cannabis for Neuropathic Pain in HIV: A Randomized, Crossover Clinical Trial*, 34 NEUROPSYCHOPHARMACOLOGY 672 (2008); *see also* B. Wilsey et al., *A Randomized, Placebo-Controlled, Crossover Trial of Cannabis Cigarettes in Neuropathic Pain*, 9 J. PAIN 506 (2008).

171. Effective Arguments, *supra* note 168, at 4 (citing HCD RESEARCH, *Physicians and Consumers Approve of Medical Marijuana Use* (June 9, 2009)).

172. *Id.*

173. *Id.*

marijuana to their patients if authorized by state law, "even if it remained illegal under federal law."[174]

B. Prohibition Has Enormous Social Costs

There is no evidence that supports that the rigorous efforts in enforcing marijuana laws in the United States translates to lowering rates of marijuana use.[175] Scholars Katherine Beckett and Steve Herbert found in their research that the collective cost of marijuana prevention is great to the public and society as a whole, a fact they believe is not even contemplated by policy makers.[176] Looking at some statistical data may be helpful in appreciating the costs that may be involved.

According to the Federal Bureau of Investigation's database, "[t]here were 658,000 arrests for marijuana possession in 2012."[177] This number dwarfs the "256,000 [arrests] for cocaine, heroin, and their derivatives" combined.[178] These arrests take officers away from more urgent crimes and have serious consequences for the arrested.[179] "The hundreds of thousands of people who are arrested each year but do not go to jail also suffer; their arrests stay on their records for years, crippling their prospects for jobs, loans, housing and benefits."[180] As such, "a single marijuana arrest can have dire consequences."[181]

The benefits of criminalization are not necessarily outweighed by marijuana prohibition.[182] Like other government initiatives,

174. *Id.*

175. *See* KATHERINE BECKETT & STEVE HERBERT, CONSEQUENCES AND COSTS OF MARIJUANA PROHIBITION 27 (2009), https://aclu-wa.org/library_files/MarijuanaProhibition.pdf.

176. *Id.*

177. Jesse Wegman, Editorial, *The Injustice of Marijuana Arrests*, N.Y. TIMES (July 28, 2014), http://www.nytimes.com/2014/07/29/opinion/high-time-the-injustice-of-marijuana-arrests.html?_r=0.

178. *Id.*

179. *Id.*; *see also* Owen Poindexter, *6 Powerful Reasons to Legalize Marijuana, from the New York Times*, ALTERNET (July 31, 2014), http://www.alternet.org/drugs/6-powerful-reasons-new-york-times-says-end-marijuana-prohibition (citing and reflecting on Wegman, *supra* note 177); *State Marijuana Laws Map*, GOVERNING: THE STATES AND LOCALITIES (July 11, 2015), http://www.governing.com/gov-data/state-marijuana-laws-map-medical-recreational.html.

180. Wegman, *supra* note 177.

181. Poindexter, *supra* note 179.

182. *Id.*

cannabis prohibition is costly.[183] The real question to ask is whether the criminalization of marijuana use has impacted the war on drugs, especially when one sees that the amount spent annually in the United States on the war on drugs is more than fifty-one billion dollars.[184] Additionally, 1.5 million people were arrested in 2013 in the United States for nonviolent drug charges.[185] The "[n]umber of people arrested for a marijuana law violation in 2013 [was] 693,482" and 88 percent of those arrested were only charged with possession.[186] However, even "[a]fter three decades, criminalization has not affected general usage [given that] about 30 million Americans use marijuana every year."[187] The peripheral issue is the "broken windows" theory—that marijuana "users are more likely to be involved in other crimes, and arresting them for possession can nip a life of crime in the bud."[188]

The New York Times makes it clear that the data does not support this theory.[189] It illustrates this point using "a 2012 Human Rights Watch report, [which] tracked 30,000 New Yorkers" who had a clean record at the time "they were arrested for marijuana possession."[190] Of those 30,000 people, 90 percent had no subsequent felony convictions.[191] "Only 3.1[percent have since] been convicted of one violent felony offense."[192] The high associated with smoking of marijuana has never been stereotyped as causing violence and there is no truthful case to be made that smoking marijuana leads to a life of crime (other than smoking marijuana).[193]

183. *See* Wegman, *supra* note 177.

184. *See Drug War Statistics*, DRUG POLICY ALLIANCE (2015), http://www.drugpolicy.org/drug-war-statistics.

185. *Id.*

186. *Id.*

187. Wegman, *supra* note 177.

188. Poindexter, *supra* note 179 (defining and then rejecting "broken windows" theory).

189. *See* Wegman, *supra* note 177.

190. *Id.*

191. *Id.*

192. *Few Arrested for Pot Become Violent Criminals: Police Offer No Public Safety Explanation for Massive Marijuana Arrests*, HUMAN RIGHTS WATCH (Nov. 23, 2012), https://www.hrw.org/news/2012/11/23/us/new-york-few-arrested-pot-become-violent-criminals.

193. Poindexter, *supra* note 179.

C. Prohibition is Racist

From the beginning of the movement to criminalize the use of marijuana in the 1930s, the campaign was rooted in xenophobia and prejudice against Mexican immigrants and African Americans, who were associated with marijuana use at the time.[194] In fact, the choice to use the Spanish-Mexican word "marijuana" to refer to the cannabis plant was commensurate with associating the plant with Mexicans.[195]

Harry Anslinger was one of the biggest supporters of criminalization.[196] His articulation of the reasons to make cannabis illegal clearly reveals his racist justification for criminalization of marijuana:

> There are 100,000 total marijuana smokers in the U.S., and most are Negroes, Hispanics, Filipinos and entertainers. Their Satanic music, jazz and swing result from marijuana usage. This marijuana causes white women to seek sexual relations with Negroes, entertainers and any others . . . . Reefer makes darkies think they're as good as white men.[197]

Needless to say, the above racist statement speaks volumes as to the raison d'être for the Anslinger push for criminalization—to detain blacks and Mexicans. The disparity in enforcement of marijuana laws indicates strong racial undertones.[198] According to a 2013 ACLU report, although blacks and whites use marijuana at about the same rate on average, "blacks are 3.7 times more likely" to be arrested for possession than whites, thus showing a disparity in enforcement which undoubtedly indicates strong racial undertones.[199] Perhaps the reason for the disparities in arrests is that "[t]he war on drugs aims its firepower overwhelmingly at

194. *See* Alfonso Serrano, *Weed All about It: The Origins of the Word 'Marijuana'*, ALJAZEERA AMERICA (Dec. 14, 2013), http://america.aljazeera.com/articles/2013/12/14/weed-all-about-ittheoriginsofthewordamarijuanaaintheus.html.

195. *Id.*

196. He became the first commissioner of the Federal Bureau of Narcotics—the DEA's predecessor. *See* Staples, *supra* note 67.

197. Nick Wing, *Marijuana Prohibition Was Racist from the Start. Not Much Has Changed*, THE HUFFINGTON POST: HUFFPOST POLITICS (Jan. 14, 2014, 2:02 PM), http://www.huffingtonpost.com/2014/01/14/marijuana-prohibition-racist_n_4590190.html.

198. *Id.*

199. Wegman, *supra* note 177.

African Americans on the street, while white users smoke safely behind closed doors."[200]

D. Legalization Will Not Lead to Increased Use

Legalizing and regulating marijuana will be more beneficial to society than prohibition, considering the level of oversight available for administration over legal markets and the lack of enforcement capacity over illegal markets. Data from the last twenty years reveal that the rate of underage drinking has been impacted by drinking laws and market campaigns, resulting in about a 10% drop in underage alcohol use since 2011.[201] Similarly, "cigarette use among high school students is at its lowest point," which apparently corresponds to an increase in "tobacco taxes and [the] growing municipal smoking limits."[202] In fact, there does not appear to be a link between the passage of medical marijuana laws and increased use in teens, rather in many cases it tends to be associated with decreased teen use instead.[203] In an interview examining a 2012 study conducted by researchers at universities in Colorado, Montana, and Oregon, that was co-authored by Daniel I. Rees, Professor of Economics at the University of Colorado, Professor Rees explained the study demonstrated "no statistical evidence that legalization increases the probability of [teen] use," and also noted that "the data [rather] showed a negative relationship between legalization and [teen] marijuana use."[204] Student surveys from states with medical marijuana laws have predictably reported decreases in teen marijuana use since the passage of those laws.[205] An annual study, carried out by the U.S. Centers for Disease Control and Prevention and reported in 2012, found that

200. *Id.*

201. Philip M. Boffey, *What Science Says about Marijuana*, N.Y. TIMES (July 30, 2014), http://www.nytimes.com/2014/07/31/opinion/what-science-says-about-marijuana.html?_r=0.

202. *Id.*

203. *See* KAREN O'KEEFE ET AL., MARIJUANA POLICY PROJECT, MARIJUANA USE BY YOUNG PEOPLE: THE IMPACT OF STATE MEDICAL MARIJUANA LAWS 2 (2011). There is some early data that regulation in Colorado correlates with a decrease in teen use. Boffey, *supra* note 201.

204. David Kelly, *Study Shows No Evidence Medical Marijuana Increases Teen Drug Use*, U. COLO. DENVER (June 18, 2012), http://www.ucdenver.edu/about/newsroom/newsreleases/Pages/medical-marijuana-teenagers.aspx.

205. O'KEEFE ET AL., *supra* note 203, at 20.

"marijuana use by Colorado high school students has dropped since the state began regulating medical marijuana in 2010."[206] A similar result is seen in California.[207] The state-sponsored California Student Survey (CSS) reporting marijuana use by California teens revealed that marijuana use took a dramatic nosedive in 1996—the year California adopted its medical marijuana law—decreasing by almost half in some age groups.[208] An independent study carried out in California in 1997–98 analyzing the effects of medical marijuana law[209] concluded that "[t]here is no evidence supporting that the passage of Proposition 215 increased marijuana use during this period."[210]

E. Cannabis Is Less Harmful than Alcohol or Tobacco

The illegal market for medical marijuana—which operates without standards, regulations, or price controls—poses the greatest hazard to public wellbeing; legalization is the inherent humane response to this market.[211] One major argument being made by supporters of legalization is to compare the negative health effects of smoking marijuana—which is a criminal act—with

206. *See* Effective Arguments, *supra* note 168 (citing Centers for Disease Control and Prevention, *Youth Risk Behavior Surveillance—United States 2011,* MORBIDITY & MORTALITY WKLY. REP. (June 8, 2012), http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf).

207. MARIJUANA POLICY PROJECT, FACTS AND COMMON MISCONCEPTIONS 11 (Feb. 13, 2014) [hereinafter FACTS AND COMMON MISCONCEPTIONS], http://www.legis.state.ak.us/basis/get_documents.asp?session=28&docid=21084; *see* GREGORY AUSTIN & RODNEY SKAGER, 11TH BIENNIAL CALIFORNIA STATEWIDE SURVEY OF CALIFORNIA STUDENTS GRADES 7, 9 AND 11, (WestEd ed. 2008), https://www.wested.org/online_pubs/hhdp/css_11th_highlights.pdf (explaining different marijuana smoking trends in grades 7, 9, and 11).

208. GREGORY AUSTIN & RODNEY SKAGER, EXECUTIVE SURVEY: 7TH BIENNIAL STATEWIDE SURVEY OF DRUG AND ALCOHOL USE AMONG CALIFORNIA STUDENTS IN GRADES 7, 9, AND 11 (Cal. Att'y Gen.'s Office 2001), http://digitalcommons.law.ggu.edu/cgi/viewcontent.cgi?article=1097&context=caldocs_agencies (internal citation omitted).

209. FACTS AND COMMON MISCONCEPTIONS, *supra* note 207, at 11.

210. AUSTIN & SKAGER, EXECUTIVE SURVEY, *supra* note 208.

211. Poindexter, *supra* note 179 ("It is the illegal market, with no standards, regulations or price controls, that poses a menace to public health. Our current federal laws, which treat cannabis as equivalent to cocaine and heroin, mostly teach teenagers that the government is completely unrealistic on matters of drug policy. Legalization is the first step in a broader initiative of treating cannabis use as a public health issue.").

the negative health effects associated with smoking tobacco—a legal, socially accepted act.[212] In 1999, the Institute of Medicine reported, "[t]here is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use."[213] This was confirmed in 2006 with the release of a study conducted to investigate the respiratory effects of marijuana smoking and cigarette smoking by the University of California at Los Angeles.[214] The study, conducted by Dr. Donald Tashkin, found that marijuana smoking was not associated with an increased risk of developing lung cancer.[215] The data suggested that "people who smoked more marijuana were not at any increased risk compared with those who smoked less marijuana or none at all."[216] A number of researchers have suggested that the evidence points to a "possible protective effect of marijuana" against lung cancer.[217] Similarly, a study conducted in 2012 found no adverse effects on pulmonary function in subjects who smoked a joint a day for seven years.[218] In fact, in a recent Pew Research Center Study, the public reported thinking of marijuana as less harmful to both personal health and society as a whole than alcohol by a wide margin.[219]

212. Effective Arguments, *supra* note 168.

213. JANET E. JOY ET AL., INSTITUTE OF MEDICINE, MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE 119 (1999). The Institute of Medicine is a division of the National Academies of Sciences, Engineering, and Medicine which was founded in 1863 by President Abraham Lincoln to "investigate, examine, experiment, and report upon any subject of science." *Who We Are*, NAT'L ACADS. SCI., ENG'G, & MED. (July 24, 2015), http://national-academies.org/about/whoweare/index.html; *About the IOM*, NAT'L ACADS. SCI., ENG'G, & MED. (July 24, 2015), http://iom.nationalacademies.org/About-IOM.aspx.

214. American Thoracic Society, *Study Finds No Link between Marijuana Use and Lung Cancer*, SCIENCE DAILY (May 26, 2006), http://www.sciencedaily.com/releases/2006/05/060526083353.htm.

215. *Id.* The study was conducted by Dr. Donald Tashkin at the University of California at Los Angeles. *Id.*

216. *Id.*

217. Effective Arguments, *supra* note 168 (quoting MiaMia Hashibe et al., *Marijuana Use and the Risk of Lung and Upper Aerodigestive Tract Cancers: Results of a Population-Based Case-Control Study*, 15 CANCER EPIDEMIOLOGY, BIOMARKERS AND PREVENTION 1829–34 (2006)).

218. Boffey, *supra* note 201; Mark J. Pletcher et al., *Association between Marijuana Exposure and Pulmonary Function over 20 Years,* J. AM. MED. ASS'N, (Jan. 11, 2012), http://jama.jamanetwork.com/article.aspx?articleid=1104848.

219. *U.S. Politics & Policy, America's New Drug Policy Landscape*, PEW RESEARCH CTR. (Apr. 2, 2014), http://www.people-press.org/2014/04/02/americas-new-drug-policy-landscape/.

Further, seventy-six percent of the American public "think that people convicted of possessing small amounts of marijuana should not have to serve time in jail."[220]

VI. STATE V. FEDERAL PERSPECTIVES: PAST AND PRESENT

Historically, the public policy of the federal government as it pertains to marijuana has undergone tremendous tidal shifts.[221] As previously discussed, marijuana was initially listed as a medical drug in the U.S. Pharmacopoeia in the early 1850s and continued to be legally permitted after the passage of the Marijuana Tax Act in 1937.[222] However, a few years later, marijuana was removed from the U.S. Pharmacopoeia and was "stripped of its designation as acceptable for medical use."[223] Then, in 1968, the federal government launched a program to grow marijuana and make it available to researchers.[224] Yet, in 1970, Congress enacted the CSA, officially classifying marijuana as a Schedule I controlled substance—partly because it was lacking an accepted medical use in the United States.[225] In spite of this designation of marijuana, the government instituted an investigational new drug (IND) program allowing "compassionate use" of marijuana to research its treatment of medical conditions.[226]

Taking a look at the case of a patient named Robert Randall, infra, for example, will demonstrate that the relief marijuana may provide some patients is real and how the extenuating circumstances make it even desperate.[227] It also shows when and what may be considered under "compassionate use," and how

220. *Id.*

221. *See infra* Part VI—State v. Federal Perspectives: Past and Present.

222. David F. Musto, *The History of the Marihuana Tax Act of 1937*, SCHAFFER LIBRARY DRUG POLICY (Feb. 1972), http://www.druglibrary.org/schaffer/hemp/history/mustomj1.html.

223. Moira Gibbons, *The Cannabis Conundrum: Medication v. Regulation*, 24 HEALTH LAWYER 1, 5 (Dec. 2011) (quoting Kathleen Ferraiolo, *From Killer Weed to Popular Medicine: The Evolution of American Drug Control Policy 1937–2000*, 19 J. POL. HIST. 147, 154–55 (2007)). The Marijuana Tax Act imposed taxes on the importation, manufacture, prescribing, dispensing, administering and giving away of marijuana, established registration requirements, and set forth penalties if tax payments were not made. *Id.*

224. Nat'l Advisory Council on Drug Abuse, *supra* note 110.

225. Aurit, *supra* note 3, at 549.

226. Nat'l Advisory Council on Drug Abuse, *supra* note 110.

227. Aurit, *supra* note 3, at 560.

patients in similar situations would benefit from legal access to marijuana.[228]

"In 1976, the Department of Health, Education, and Welfare (HEW) approved a petition filed on behalf of Robert Randall, a twenty-eight-year-old glaucoma patient."[229] Randall requested a supply of government marijuana, grown for research, to aid in his treatment of glaucoma.[230] He demonstrated that he had been subjected to an exhaustive regime of examinations and trials of every available medication, but they had failed to successfully treat his glaucoma.[231] In 1976, a federal judge ruled that his use of marijuana was a "'medical necessity.'"[232] However, in 1978, federal agencies sought to silence Randall as an outspoken proponent of legalization by disrupting his legal access to marijuana.[233] Randall sued the FDA, the DEA, the NIDA, the DOJ, and HEW to resume his legal use.[234] Consequently, NIDA "resumed supplying Randall with medical marijuana in settlement of a lawsuit that he had filed in 1978."[235] Following Randall's success, "a modest number of additional individuals and their physicians [came forward] to petition the federal government for access to medical marijuana through the IND process."[236] However, in 1992 the Department of Health and Human Services (HHS) took over after HEW ended the marijuana IND program, and as a result did not admit new enrollees.[237]

In the 1980s, the Reagan Administration's drug control policy was "Just Say No."[238] It was firm, it was resolute, and it went unchallenged by anything other than fringe protest.[239] Not until the Clinton Administration did the DEA start to confront a

228. *Id.*
229. Gibbons, *supra* note 223, at 5.
230. *Id.*
231. *Id.*
232. United States v. Randall, 104 Daily Wash. L. Rptr. 2251 (D.C. Super. Ct. 1976).
233. Gibbons, *supra* note 223, at 5
234. *Randall*, 104 Daily Wash L. Rptr. 2251.
235. Gibbons, *supra* note 223, at 5.
236. *Id.*
237. *Id.* ("However, NIDA continues to provide government-grown marijuana to a handful of remaining patients.").
238. *See* Gibbons, *supra* note 223, at 5.
239. *Id.*

groundswell of medical marijuana advocacy at the state level.[240] Just a year before Clinton took office, in 1992, "the DEA denied a petition to reschedule marijuana from Schedule I to Schedule II, citing lack of adequate and well-controlled studies proving the drug's efficacy and no expert recognition of its medicinal value."[241] By 1994, the DEA put in place a policy that would "assist state and local law enforcement agencies [fight] to oppose marijuana legalization."[242] This policy assistance did not seem to be effective given that five states still implemented medical marijuana programs in the early 2000s during the George W. Bush Administration.[243] After the terrorist attacks of September 11, 2001, the Bush Administration reallocated resources, including some of the DEA's manpower and budget, to combat terrorism.[244] The administration was still vehemently opposed to the legalization of medical marijuana.[245] The DOJ campaigned forcefully against medical marijuana programs under the Clinton and George W. Bush Administrations.[246] As a corollary of this continued policy, the DEA "raided hundreds of medical marijuana dispensaries and threatened to derail the careers of physicians who recommended marijuana use to their patients."[247]

The Supremacy Clause of the U.S. Constitution, as the core foundation of the federal government's power over individual states, makes it clear that individual states cannot interfere with the operation of the laws enacted by the federal government.[248] Therefore, the individual states should not be able to circumvent the federal laws banning the use of marijuana for medical

240. *Id.*

241. *Id.*

242. *Id.*

243. *Id.* S*ee generally Historical Timeline*, *supra* note 33.

244. Gibbons, *supra* note 223, at 5; s*ee also* Dep't of Justice, *Fact Sheet: Justice Department Counter-Terrorism Efforts Since 9/11* (2008), http://www.justice.gov/archive/opa/pr/2008/September/08-nsd-807.html.

245. Gibbons, *supra* note 223, at 5.

246. *Id.*

247. Mikos, *supra* note 153, at 633.

248. U.S. CONST. art. VI, § 2. The Supremacy Clause reads:

> The Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be supreme Law of the Land; and the judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding. *Id.*

purposes, which have been enacted by the federal government.[249] Consequently, the issue of preemption arises when a federal and state statute conflict on the same subject matter.[250] Federal law preempts state law on the matter of regulating controlled substances.[251] The Supremacy Clause requires that courts follow federal rather than state law.[252] While the federal government can enforce its drug policies, it remains uncertain whether federal enforcement agencies will investigate and prosecute individuals acting against such policies under state law or will instead conserve resources for more urgent matters.[253]

In October of 2009, the Obama Administration directed the then U.S. Deputy Attorney General, David W. Ogden, to send a memo (Ogden Memo) to federal prosecutors encouraging them not to prosecute people who distribute marijuana for medical purposes in accordance with state law.[254] The Ogden Memo was intended to give clarification and guidance to federal prosecutors in states that had enacted legislation allowing the medical use of marijuana.[255] The Ogden Memo did not decriminalize marijuana or provide a legal defense to any violations of federal law, the memo merely acknowledged the use of economic triage in prosecutorial matters:

> [A]s a general matter, pursuit of [traffickers of illegal drugs] should not focus federal resources in your States on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana. For example, prosecution of individuals with cancer or other serious illnesses who use marijuana as part of a recommended treatment regimen consistent with applicable state law, or those caregivers in clear and unambiguous compliance with existing state law who provide such individuals with

249. *See, e.g.*, Kathryn L. Blaine, S*upreme Court "Just Says No" to Medical Marijuana: A Look at* United States v. Oakland Cannabis Buyers' Cooperative, 39 HOUS. L. REV. 1195, 1217–18 (2002).

250. *Id.*; s*ee* Cooper v. Aaron, 358 U.S. 1, 18 (1958).

251. Blaine, *supra* note 249, at 1219.

252. Gonzales v. Raich, 545 U.S. 1, 29 (2005).

253. Claire Frezza, *Medical Marijuana: A Drug without a Medical Model*, 101 GEO. L.J. 1117, 1127 (2013).

254. Ogden Memo, *supra* note 136.

255. *Id.*

> marijuana, is unlikely to be an efficient use of limited federal resources.[256]

Importantly, while the Ogden Memo acknowledged the broad discretion enjoyed by federal prosecutors, it urged that limited federal agency resources not be spent investigating and prosecuting those complying with existing state laws.[257]

It was first thought that the Ogden Memo represented a groundbreaking shift in federal drug policy—especially given it was the federal government's first time explicitly renouncing enforcement against persons who used the drug without violating state law.[258] However, the interpretations of federal policy are as varied as the commentary.[259] One commentator stated that while the Memo "reflects the [Obama Administration's] belief that federal law enforcement resources could be better spent enforcing other federal criminal laws" aimed at preventing horrors like terrorism, "it does not constitute an endorsement of medical marijuana."[260] The above policy has been drafted "to empower state governments to regulate medical marijuana" based on local choices.[261] The memo therefore implicitly recognizes that some states do not share the federal government's hostility towards marijuana.[262]

Thus, in 2011, states and cities were continuing to move in the direction not only of decriminalization, but also towards the establishment of "'clear and unambiguous' distribution programs."[263] As a result, Oakland's city attorney asked the DOJ for guidance concerning the implementation of a 2010 ordinance calling for the city to accept fees from and issue permits to large-scale commercial marijuana producers.[264] U.S. Attorney Melinda Haag retorted that growing, distributing, and possessing marijuana violates federal law under the CSA unless it is part of a federally

256. *Id.*
257. *Id.*
258. *Historical Timeline, supra* note 33.
259. *See, e.g.*, Mikos, *supra* note 153, at 639–40.
260. *Id.*
261. *Id.* at 640.
262. *See* Ogden Memo, *supra* note 136.
263. Karen O'Keefe, *State Medical Marijuana Implementation and Federal Policy*, 16. J. HEALTH CARE L. & POL. 39, 53 (2013) [hereinafter *State Implementation*] (citing OAKLAND, CAL., ORDINANCE 13033 (July 27, 2010)).
264. *Id.*

approved research project.[265] She clarified that "while the department does not focus its limited resources on seriously ill individuals who use marijuana . . . in compliance with state law . . . we will enforce the CSA vigorously against individuals and organizations that participate in unlawful manufacture and distribution activity involving marijuana, even where such activities are permitted under state law."[266] Similarly, in a response to Washington state's governor Christine Gregoire's request for clarification from the DOJ on legislation to regulate dispensaries in her state, the DOJ responded by reiterating the Oakland city response and adding that "state employees who conduct[] activities mandated by the Washington legislative proposals would not be immune from liability under the CSA."[267] The year 2011 is generally marked by similar letters from U.S. Attorneys to inquiring elected officials in states such as Arizona, Colorado, Hawaii, Maine, Montana, Rhode Island, and Vermont, giving virtually the same response: "the CSA may be vigorously enforced against those individuals and entities who operate large marijuana production facilities."[268] In the spring of 2011, the DEA raided marijuana dispensaries in many states, and in particular in Washington, seizing marijuana.[269]

The DOJ then issued the Cole Memorandum to DOJ attorneys in June 2011 (2011 Cole Memo) stating that commercial cultivation or distribution of marijuana is subject to federal criminal

265. *Id.*

266. *Id.* (quoting Letter from Melinda Haag, U.S. Att'y for the N. Dist. of Cal., to John Russo, Oakland City Att'y (Feb. 1, 2011) (on file with the Journal of Health Care Law & Policy)); *see also* Michael Roberts, *Medical Marijuana: Does Melinda Haag's Memo Foreshadow Federal MMJ Raids in Colorado?*, WESTWORD (Mar. 25, 2011), http://www.westword.com/news/medical-marijuana-does-melinda-haags-memo-foreshadow-federal-mmj-raids-in-colorado-5838853.

267. *State Implementation*, *supra* note 263, at 54. Governor Christine Gregoire vetoed the portion of the law that would have regulated dispensing to avoid putting State employees in legal danger. *Id.* Fearing federal policy, the state missed an opportunity to regulate its dispensaries, a striking problem when noted that Seattle alone has over 100 dispensaries. *Id. See* Jonathan Martin, *Seattle Pot Dispensaries Finding Business Climate No Longer Sunny,* SEATTLE TIMES (Sept. 5, 2012), http://www.seattletimes.com/seattle-news/seattle-pot-dispensaries-finding-business-climate-no-longer-sunny/.

268. *State Implementation*, *supra* note 263, at 55.

269. *Id.* at 53–55; Rob Kauder, *Authorities Raid Spokane Medical Marijuana Dispensaries*, KXLY (Sept. 9, 2011, 5:11 PM), http://www.kxly.com/news/Authorities-Raid-Spokane-Medical-Marijuana-Dispensaries/680580.

prosecution even if the operation complies with state law.[270] The 2011 Cole Memo similarly recognized that it was "likely not an efficient use of federal resources to focus enforcement efforts on individuals with cancer or other serious illness who use marijuana as part of a recommended treatment regimen consistent with applicable state law, or their caregivers."[271] The 2011 Cole Memo appears to be more limited than the Ogden Memo, defining caregivers only as those caring for the seriously ill, "not commercial operations cultivating, selling or distributing marijuana."[272]

Thus, the 2011 Cole Memo clarified that the Ogden Memo was never intended to shield large-scale manufacturers of marijuana with "revenue projections of millions of dollars based on the planned cultivation of tens of thousands of cannabis plants" regardless of whether they apparently comply with state law.[273] Subsequently, medical marijuana proponents complained that the 2011 Cole Memo apparently contradicted the Ogden Memo because while the Ogden Memo emphasized that prosecutors do not need to prosecute individuals and caregivers who were in clear-cut compliance with state medical marijuana laws, the 2011 Cole Memo apparently encouraged prosecution.[274]

In June 2011, the DEA, working closely with NIDA, rejected a petition to reclassify marijuana from Schedule I to either Schedule III, IV, or V.[275] The FDA concluded after its medical evaluation of marijuana that the drug met three of the eight factors to specifically categorize it in Schedule I.[276]

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270. Letter from James M. Cole, Deputy Att'y Gen., to U.S. Attorneys (June 19, 2011), *Guidance Regarding the Ogden Memo in Jurisdictions Seeking to Authorize Marijuana for Medical Use*, U.S. DEP'T OF JUSTICE: OFFICE OF THE DEPUTY ATT'Y GEN. (June 29, 2011) [hereinafter 2011 Cole Memo], https://www.justice.gov/sites/default/files/oip/legacy/2014/07/23/dag-guidance-2011-for-medical-marijuana-use.pdf.

271. *Id.*

272. *Id.*; *State Implementation*, *supra* note 263, at 55.

273. 2011 Cole Memo, *supra* note 270, at 2.

274. Gibbons, *supra* note 223, at 5.

275. Denial of Petition to Initiate Proceedings to Reschedule Marijuana, 76 Fed. Reg. 40552–01 (July 8, 2011).

276. *Id.* The FDA cited marijuana's high substantive abuse potential, lack of any currently accepted medical use in treatment, and lack of accepted safety criteria for use under medical supervision. The eight factors used by the FDA in evaluating drugs is set forth in 21 U.S.C. § 811(c) (2012):

(1) [Its] actual or relative potential for abuse;

(2) Scientific evidence of pharmacological effect, if known;

On August 29, 2013, the DOJ announced an update to the marijuana enforcement policy in a memo from Deputy Attorney General James M. Cole (2013 Cole Memo).[277] In a press release announcing their guidance, the DOJ stated that while marijuana remains illegal federally, the DOJ expects states like Colorado and Washington to create "strong, state-based enforcement efforts . . . [in return] deferring [the] right to challenge their legalization laws at this time."[278] It warned that the department reserved the right to challenge the states at any time they feel it is necessary.[279] The pendulum has swung from blanket federal enforcement and outright resistance to the development of local regulation towards a greater autonomy in state self-governance, allowing states to develop systems to monitor and enforce their own tailored marijuana laws.[280] However, the DOJ has made it consistently clear that marijuana remains an illegal drug under the CSA and that federal prosecutors will not hesitate to act if the states are unable to moderate the industry appropriately.[281]

VII. STATE V. FEDERAL POLICIES: SOME CASE LAW SHAPING THE

(3) The state of current scientific knowledge regarding the drug or other substance;
(4) Its history and current pattern of abuse;
(5) The scope, duration and significance of abuse;
(6) What, if any, risk there is to public health;
(7) Its psychotic or physiological dependence liability; and
(8) Whether the substance is an immediate precursor of a substance that is already controlled under [the federal Controlled Substances Act].

277. Letter from James M. Cole, Deputy Att'y Gen., to U.S. Attorneys, *Guidance Regarding Marijuana Enforcement*, U.S. DEP'T OF JUSTICE: OFFICE OF THE DEPUTY ATT'Y GEN. (Aug. 29, 2011), [hereinafter 2013 Cole Memo], http://www.justice.gov /iso/opa/resources /305201382913275685746 7.pdf.

278. Press Release, Dep't of Justice, Justice Dep't Announces Update to Marijuana Enforcement Policy (Aug. 29, 2013), https://www.justice.gov/opa/pr /justice-department-announces-update-marijuana-enforcement-policy.

279. 2013 Cole Memo, *supra* note 277.

280. *See Historical Timeline*, *supra* note 33.

281. Press Release, Dep't of Justice, *supra* note 278 ("To this end, the Department identifies eight (8) enforcement areas that federal prosecutors should prioritize. These are the same enforcement priorities that have traditionally driven the Department's efforts in this area. Outside of these enforcement priorities, however, the federal government has traditionally relied on state and local authorizes to address marijuana activity through enforcement of their own narcotics laws. This guidance continues that policy.").

DEBATE

A study of the interplay between federal statutes, state statutes, administrative agency guidance, and enforcement would not be complete without case law. Case law illustrates the actual limits and confines of power and, as such, has massive effects on practical enforcement and legislative efforts.

A. Gonzales v. Raich

As stated above in regard to *Gonzales v. Raich*, California passed the Compassionate Use Act in 1996, which allowed for the use of medical marijuana.[282] The defendants were properly using marijuana under the Compassionate Use Act and both were growing marijuana plants at home for their own use.[283] Federal DEA agents seized and destroyed their marijuana plants.[284] Defendants were compliant with state laws when arrested, but guilty under federal DEA laws at the time.[285] Defendants sued the Attorney General, arguing that Congress had exceeded their interstate commerce clause authority in legislating the behavior of a local citizen, consuming a locally grown herb in his own home.[286] The Supreme Court held that the Commerce Clause authorizes Congress to prohibit the local cultivation and use of marijuana even if it is in compliance with California law.[287] Thus, *Gonzales v. Raich* simply stands for the fact that Congress has the authority, under the Commerce Clause, to prohibit marijuana use at the federal level.[288]

B. United States v. Oakland Cannabis Buyers Cooperative

California Proposition 215 was a voter initiative approved in 1995 which declared that "seriously ill Californians have the right to obtain and use marijuana for medical purposes."[289] Under the law, a patient or a patient's caregiver, upon the recommendation

282. 545 U.S. 1, 5 (2005).
283. *Id.* at 6–7.
284. *Id.* at 7.
285. *Id.* at 7–9.
286. *Id.* at 7–8.
287. *Id.* at 32–33.
288. *Id.* at 5.
289. Compassionate Use Act of 1996, CAL. HEALTH & SAFETY CODE § 11362.5 (West 1996).

or approval of a physician, may possess or cultivate marijuana for medical purposes and will not be punished under California law.[290] In anticipating the protection of the Compassionate Use Act, several medical marijuana dispensaries and cooperatives planned on distributing marijuana to qualified patients.[291]

The federal government disagreed with the constitutionality of Proposition 215 and, in early 1998, filed separate lawsuits against six marijuana cooperatives, stating that these six cooperatives were functioning in violation of federal law.[292] The DOJ felt that these cooperatives "violated the [CSA's] prohibitions on distributing, manufacturing, and possessing with the intent to distribute or manufacture a controlled substance."[293] The government also filed motions for preliminary injunction, permanent injunction, and summary judgment in each case.[294] The U.S. District Court for the Northern District of California held that in light of the Supremacy Clause of the U.S. Constitution, the cooperatives' conduct likely violated federal law.[295] Consequently, the district court granted preliminary injunction, ordering that the six cooperatives refrain from violating the CSA by discontinuing to engage in illegal distribution of marijuana.[296]

One of the dispensaries, Oakland Cooperative, did not comply with the injunction, so the district court held Oakland Cooperative in contempt and modified the preliminary injunction to give authority to the U.S. Marshall to seize Oakland Cooperative's offices.[297] Although its offices were padlocked, Oakland Cooperative requested that the court modify the injunction to allow marijuana distribution to patients with a medical need. The district court rejected the request.[298] Oakland Cooperative eventually changed its mind and complied with the injunction, resulting in the court vacating the modification in relation to

290. *Id.*
291. Blaine, *supra* note 249, at 1199.
292. *Id.* at 1200.
293. United States v. Oakland Cannabis, 532 U.S. 483, 487 (2010).
294. United States v. Cannabis Cultivator's Club, 5 F. Supp. 2d 1086, 1093 (N.D. Cal. 1998). Six individual lawsuits were reassigned as related cases to the U.S. District Court for Northern District of California. *Id.*
295. *Id.* at 1105.
296. United States v. Cannabis Cultivator's Club, No. C 98–0085 CRB, 1999 WL 111893, at *1 (N.D. Cal. Feb. 25, 1999).
297. *Oakland Cannabis*, 532 U.S. at 487.
298. *Id.* at 488.

seizing the Oakland Cooperative premises.[299] Oakland Cooperative eventually appealed three of the district court's orders.[300] The Ninth Circuit, after reviewing the district court orders, opined that it did not have jurisdiction in two of the orders, but it did review the third order of an appeal from the motion to modify.[301] The Ninth Circuit accepted Oakland Cooperative's argument in favor of a necessity defense. The court therefore reversed the order denying the modification and remanded the issue, instructing the district court to reconsider Oakland Cooperative's "request for a modification that would exempt from the injunction distribution to seriously ill individuals who need cannabis for medical purposes."[302]

On remand, the district court modified the injunction against the six cooperatives to allow seriously ill individuals access to marijuana if they are able to establish a medical necessity for marijuana.[303] As a result, the government appealed the district court's modification order.[304] The U.S. Supreme Court reversed the Ninth Circuit and held that "there is no medical necessity exception [or defense] to the Controlled Substances Act's prohibitions on manufacturing and distributing marijuana."[305] In other words, the Oakland Cannabis Cooperative claimed there was an implied common-law medical necessity exception contained in the CSA that the Ninth Circuit was willing to recognize.[306] The

299. *See* United States v. Oakland Cannabis Buyers' Coop., 190 F.3d 1109, 1113 (9th Cir. 1999), *rev'd*, 532 U.S. 483 (2001).

300. *Id.* at 1111 (The three orders included: "(a) an order denying OCBC's motion to dismiss the complaint on the ground that an Oakland City ordinance makes it immune from liability under 21 U.S.C § 855(d); (b) an order subsequently purged and vacated that found OCBC in contempt of the injunction; and (c) an order denying OCBC's motion to modify the injunction to permit cannabis distribution to persons having a doctor's certificate [stating] that marijuana is a medical necessity for them.").

301. *Oakland Cannabis Buyers' Coop.*, 190 F.3d at 1111.

302. *Id.*

303. United States v. Oakland Cannabis Buyers' Coop., No. C 98–0088 CRB, 2000 WL 1517166, at *2 (N.D. Cal. July 17, 2000)*; see also* Blaine, *supra* note 249, at 1202 (stating "that the Government failed to offer any evidence to rebut Oakland Cooperative's argument that cannabis is medically necessary for seriously ill individuals.").

304. *See* Petition for Writ of Certiorari, *Oakland Cannabis Buyers' Coop.*, 190 F.3d 1109 (No. 00–151).

305. United States v. Oakland Cannabis Buyers' Coop., 532 U.S. 483, 483 (2001).

306. *See Oakland Cannabis Buyers' Coop.*, 2000 WL 1517166, at *1.

Supreme Court clarified that the only exception contained in the CSA for Schedule I drugs like marijuana was that for government-approved research projects.[307] The mere fact that marijuana is a Schedule I drug means that Congress does not acknowledge any medical use for marijuana.[308]

This case stands for the proposition that the CSA outlaws all uses of medical marijuana, that there is no federal common law necessity defense to the CSA, and therefore marijuana is still banned federally.[309]

C. Pearson v. McCaffrey

Pearson v. McCaffrey made it clear that the U.S. District Court for the District of Columbia would not create protections for physicians on First, Ninth, or Tenth Amendment grounds.[310] A group of physicians practicing medicine in states with medical marijuana provisions challenged the constitutionality of the CSA.[311] The physicians wanted to be sheltered from federal laws and continue to recommend and prescribe marijuana.[312] Upon review, the *Pearson* court refused to grant a preliminary injunction against the government, asserting that "even if marijuana were a panacea for all diseases, the [c]ourt does not have the authority to grant [p]laintiffs' request."[313] The court encouraged the plaintiffs to submit their case to the appropriate forum—the DEA—and ask it to reconsider rescheduling marijuana to a different class.[314]

D. Emerald Steel Fabricators, Inc. v. Bureau of Labor & Industries

In *Emerald Steel Fabricators, Inc. v. Bureau of Labor & Industries*, the Oregon Supreme Court held that an employer did not have to make accommodations for an employee's medical marijuana use.[315] In articulating this holding, the court stated, "[t]o the extent that

307. *Oakland Cannabis Buyers' Coop.*, 532 U.S. at 483.
308. *Id.* at 484.
309. *See id.* at 490.
310. 139 F. Supp. 2d 113, 113 (D.D.C. 2001).
311. *Id.* at 115–17.
312. *Id.* at 117.
313. *Id.* at 125.
314. *See id.*
315. Emerald Steel Fabricators, Inc. v. Bureau of Labor & Indus., 230 P.3d 518, 520 (Or. 2010).

[the Oregon medical marijuana statute] affirmatively authorizes the use of medical marijuana, federal law preempts that subsection [of state law], leaving it 'without effect.'"[316] Furthermore, the Oregon Supreme Court relied on its decision in *Michigan Canners & Freezers Association v. Agricultural Marketing and Bargaining Board*, and consequently held that the Oregon medical marijuana statute was preempted based on obstacle preemption by the CSA.[317] In *Michigan Canners*, the U.S. Supreme Court held that "federal law prohibited food producers' associations from interfering with an individual food producer's decision whether to bring that individual's products to the market" or to utilize cooperative associations.[318] Although *Michigan Canners* followed federal law on the issue for the most part, the Court permitted associations representing food producers to apply to a state board for authority to be "the exclusive bargaining agent for all producers" of a specific product:

> Under Michigan's system, if an association's membership constitutes more than 50% of the producers of a particular commodity, and its members' production accounts for more than 50% of the commodity's total production, the association may apply to the state Agricultural Marketing and Bargaining Board for accreditation as the exclusive bargaining agent for all producers of that particular commodity.[319]

Although the U.S. Supreme Court held that the state law did not directly contradict the federal law, the fact remains that the state law authorized an association to ignore federal prohibitions, which created enough of an obstacle to the federal law's purpose to make the state law void due to preemption.[320]

There are situations where state and federal legislatures have differing opinions on whether medical marijuana use should be prohibited.[321] The states that have the most successfully implemented medical marijuana programs simply do not prosecute medical marijuana use, leaving any medical marijuana prosecution

316. *Id.* at 529.

317. *Id.*

318. *Id.* at 528; *see* Michigan Canners & Freezers Ass'n v. Agric. Mktg. & Bargaining Bd., 467 U.S. 461, 462 (1984).

319. *Id.* at 466.

320. *Id.* at 478.

321. *See supra* text accompanying note 136.

and regulation to the federal government.[322] This leaves individuals who use medical marijuana under state law vulnerable to prosecution for violation of federal law, even though the state may not prosecute that individual.[323]

VIII. THE COMPASSIONATE USE ACT: THE CASE FOR CALIFORNIA AS A STANDARD?

Voters in California passed a state medical marijuana initiative in 1996.[324] California was the first jurisdiction to decriminalize use and cultivation of marijuana under its Compassionate Use Act, known as Proposition 215, which "permits patients and their primary caregivers, with a physician's recommendation, to possess and cultivate marijuana for the treatment of AIDS, cancer, muscular spasticity, migraines, and several other disorders . . . ."[325] The federal government responded swiftly to the passage of this first state marijuana law.[326] In 1997, the Clinton Administration issued a harsh statement indicating the steps the government would take to kill the new medical marijuana movement through its former general, Barry McCaffrey.[327] McCaffrey threatened to prosecute persons who supplied medical marijuana, revoke the prescription-writing authority of physicians who recommended marijuana to patients, and deny various federal benefits (including licenses) to anyone who used marijuana under the California law.[328]

The federal government's policy on marijuana purportedly adheres to the underlying principle enunciated in the CSA—that marijuana has "no currently accepted medical use" and therefore is rightfully classified as a Schedule I drug.[329] Yet the federal government has been sending mixed signals to the states concerning the standing of medical uses for marijuana, as marked by the Ogden and Cole memoranda encouraging federal prosecutors not to prosecute those who obtain marijuana for

322. *See supra* text accompanying note 136.

323. *See supra* text accompanying note 136.

324. CAL. HEALTH & SAFETY CODE § 11362.5.

325. *Historical Timeline*, *supra* note 33.

326. Notice, Administration Response to Arizona Proposition 200 and California Proposition 215, 62 Fed. Reg. 6164–01 (Feb. 11, 1997); Mikos, *supra* note 153, at 637.

327. 62 Fed. Reg. 6164–01; *see supra* text accompanying note 240–43.

328. 62 Fed. Reg. 6164–01.

329. *See supra* Part II (discussing history of medical marijuana).

medical purposes.[330] Yet at the same time, the fight against medical marijuana persisted during George W. Bush's Administration, which conducted "nearly two hundred raids on [medical] dispensaries in California," and even warned landlords who did not promptly evict marijuana-dispensing tenants that it would seize their property.[331]

The California Compassionate Use Act established requirements for physicians desiring to recommend marijuana to patients, as well as the minimum qualification process to be used by doctors and those looking to obtain marijuana for medical purposes.[332] The program requires that an attending physician licensed in California, upon examining a patient, determine whether the patient has a serious medical condition requiring the use of marijuana for treatment.[333] The question is what is meant by "serious medical use?" The definition is broad, and includes conditions such as "arthritis, migraines, cancer, multiple sclerosis, seizures, severe nausea, and any other chronic or persistent condition" that would inhibit a major life activity or condition, and which, if not treated, may cause grave harm to a patient's safety, or even to his or her physical or mental health.[334] This is somewhat different from what prevails in New Mexico, where the patient must be unable to get adequate relief therapy before the physician can

330. *See supra* Part VI (discussing the tension between the federal government and the state governments regarding legalization).

331. Aurit, *supra* note 3, at 554.

332. Compassionate Use Act of 1996, CAL. HEALTH & SAFETY CODE § 11362.5; Gibbons, *supra* note 223, at 5.

333. Gibbons, *supra* note 223, at 7.

334. *Id.* Under the California Medical Marijuana Program, physician marijuana recommendations must be documented in the patient's medical record, which is then used by the patient to obtain an identification card through the health department in the county where the patient resides. After the submission of an application and payment of the requisite fees as required by the state and county, the health department proceeds to review the application for approval or rejection. In so doing, the department obtains a patent's photo, verifies the validity of the attending physician's credentials, i.e., that he holds a California physician license in good standing. It also contacts the physician to ensure that the patient-provided medical records recommending marijuana are authentic and appropriate. Patients with an ID card can purchase or grow marijuana for medical purposes. *See Medical Marijuana Program Frequently Asked Questions*, CAL. DEP. OF PUB. HEALTH, http://www.cdph.ca.gov/programs/MMP/Pages/MMPFAQ.aspx (last updated Mar. 10, 2014).

recommend marijuana.[335] On the contrary, the California Medical Board guidelines for physicians expressly suggest that a patient does not have to wait until all standard medications have been tried and failed before recommending marijuana.[336] In fact, all that is expected from a California physician is to weigh the risk/benefit ratio of medical marijuana, and if marijuana tends to be as good as or better than other medications, then the physician may prescribe it under state law.[337] The guidelines do not require, nor do they specifically recommend that other medications be tried first before using marijuana.[338] These guidelines may be the reason why some scholars have stated that "the real beneficiaries of the medical marijuana movement are doctors who hand out marijuana medical cards like candy."[339] In California, the marijuana boom was so lucrative that "robodoctors" set up offices equipped with a nurse and video conferencing capabilities, and charge each patient to issue a medical marijuana card after listening to the patient's medical complaints over the internet.[340] The marijuana card is only valid for six months and patients must pay an additional fee to renew the prescription.[341]

In comparison, and perhaps also worth emulating, is New Mexico's marijuana program. This program appears to be much more regulated, standing out probably because of the comprehensive way that the New Mexico State Department of Health (NMDOH) monitors the production and distribution of marijuana.[342] The NMDOH would issue licenses to producers and distributors of medical marijuana.[343] Under the Lynn and Erin Compassionate Use Act in New Mexico, patients receive protection from state prosecution if, firstly, their physician certifies that they have one of the listed medical conditions,[344] secondly, that employing regular treatment is unlikely to be effective, and thirdly,

335. *See* Reid, *supra* note 137, at 196–98.

336. Compassionate Use Act of 1996, CAL. STAT. § 11362.5; *see also* Gibbons, *supra* note 223, at 7.

337. Gibbons, *supra* note 223, at 7.

338. Gibbons, *supra* note 223, at 7–8.

339. Reid, *supra* note 137, at 195.

340. *Id.*

341. *Id.* at 196.

342. *See* N.M. STAT. ANN. § 26-2B-7 (West, Westlaw through Ch. 2 of 2nd 2015 Reg. Sess.); Reid, *supra* note 137, at 196.

343. Reid, *supra* note 137, at 196–97.

344. *Id.* at 197.

that the benefit of using marijuana for that patient in question outweighs the risk of its use.[345] Upon receiving the certification, the patient could then apply to the state for a registry card.[346] If the state approves, it then issues the patient a registry card.[347] Likewise, the state seems to be liberal towards its citizens, as it gives patients the choice of growing up to sixteen marijuana plants for personal use.[348] However, as with the California program, it has its shortcomings not intended by the legislature.[349] At the New Mexico Medical Board's April 2013 hearing, the board heard testimony that some patients were being approved for the program who did not meet the established criteria to legally use medical marijuana.[350] Some patients even received certification over the phone through Skype, and one clinic is said not to have even examined its patients before confirming their eligibility for the program.[351] It was found that "[o]f the 12,977 applications submitted to the State Department of Health since the program began in 2007, only 25 resulted in 'flat-out denials.'"[352] This demonstrates that it is not common for attending physicians to turn down patients. One physician approved ninety-eight percent of the patients he let into his marijuana program.[353] These problems are being alleviated by the proposal of new rules by state regulators that require doctors and other health care providers periodically to re-diagnose the patient and to notify the patient's health care providers.[354] Whether the proposed regulations will actually curtail the abuse of the program by some doctors is uncertain.[355]

What is certain is that even with more oversight by a patient's state, marijuana distributors and marijuana producers, there is no

345. *Id.*
346. *Id.*
347. *Id.*
348. *Id.*
349. *See id.* at 196–98.
350. Colleen Heild, *New Light Shed on New Mexico Medical Marijuana*, ALBUQUERQUE J. (Aug. 11, 2013), http://www.abqjournal.com/245506/news/new-light-shed-on-nm-medical-marijuana.html.
351. *Id.*
352. *Id.*
353. *Id.*
354. Phaedra Haywood, *Critics Blast Proposed New Rules for Pot Program*, SANTA FE NEW MEXICAN (Aug. 3, 2013), http://www.santafenewmexican.com/news/health_and_science/article_79c2f192-b10c-554a-92df-695c77d16637.html.
355. *Id.*

guarantee that the use of medical marijuana will be narrowly tailored for use by only those in dire need without some taking advantage of the lucrative business it tends to generate.[356] Taking a closer look at the programs in California and New Mexico reveals that even with tighter control of medical marijuana, abuse of the programs cannot be eradicated completely.[357]

IX. CONCLUSION

The supposed non-enforcement policy of the federal government encourages federal prosecutors not to go out of their way to prosecute marijuana users who follow state medical laws in an effort to better utilize federal prosecutorial resources.[358] This policy does not give carte blanche to patients, producers, and distributors as the federal prosecutors can, and do, exercise discretion, occasionally pursuing cases.[359] States are increasingly ignoring their federal responsibilities and creating their own regulatory frameworks for an industry the federal government officially condemns.[360]

The states have been moving towards recognizing and controlling the medical marijuana industry—and not merely decriminalizing it—since 2009.[361] The states are individually evaluating the risks and benefits involved in recognizing the therapeutic value of marijuana—which has traditionally been a part of the FDA's role in the regulations behind the safety and effectiveness of drugs—finding that the benefits in recognizing such therapeutic value in marijuana outweigh the risks.[362] To most

356. *See generally* Peter St. Cyr, *No Easy Ride*, SANTA FE REP. (July 9, 2013), http://www.sfreporter.com/santafe/article-7540-no-easy-ride.html. In 2013, New Mexico reported U.S.D. 3.3 million in total sales by licensed producers and distributors of marijuana. *Id.*

357. Reid, *supra* note 137, at 194–99.

358. Mikos, *supra* note 153, at 667–69.

359. *See* Tim Dickinson, *Obama's War on Pot: In a Shocking About-Face, The Administration Has Launched a Government-Wide Crackdown on Medical Marijuana*, ROLLING STONE (Feb. 16, 2012), http://www.rollingstone.com/politics/news/obamas-war-on-pot-20120216 (stating federal authorities under the Obama administration are regulating medical marijuana more strictly than past presidents, regularly pursuing distributors in compliance with state laws).

360. *See State Implementation*, *supra* note 263, at 49–53 (providing an overview of state marijuana regulations).

361. *Id.*

362. Gibbons, *supra* note 223, at 7.

efficiently harmonize rhetoric, the federal government should align its policies to match the states' policies by officially declining to use its limited resources on businesses and individuals in compliance with well-regulated state medical marijuana laws. Also, rescheduling marijuana from Schedule I to Schedule III or lower would "allow[] marijuana to be prescribed, recommended, dispensed from pharmacies, and possessed or manufactured by those authorized to do so under state medical marijuana laws."[363]

However, one of the major arguments against the federal government reclassifying marijuana from a Schedule I substance to Schedule III is that legalizing marijuana for medical purposes may act as a slippery slope, setting the country sliding towards outright marijuana legalization.[364] Critics contend that "dispensaries, retailers, and growers of marijuana" are the only parties that stand to profit from reform.[365] There needs to be a well-developed regulatory system to ensure patient safety and prevent against blatant abuse, but when traditional medications fail, providing access to marijuana for medical purposes is a humane approach to a difficult question.[366] The inaction of Congress with respect to the CSA has forced the individual states to reexamine the goals of the CSA.[367] Justice O'Connor aptly noted in her dissent in *Gonzales v. Raich* that "[o]ne of federalism's chief virtues, of course, is that it promotes innovation by allowing for the possibility that 'a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.'"[368]

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363. *State Implementation*, *supra* note 263, at 58. O'Keefe believed that the best, most comprehensive way to harmonize federal and state medical marijuana policies would be for Congress to pass H.R. 689, which would result in marijuana being scheduled as III or lower. *Id.*

364. James Bell, *Medical Marijuana—A Slippery Slope?*, GEORGIA CARE PROJECT (Mar. 25, 2015), http://www.gacareproject.com/medical-marijuana-a-slippery-slope/.

365. Reid, *supra* note 137, at 191 ("[W]ithout increased regulation or taxation that is possible through outright legalization, the medical marijuana option would merely exchange one drug-trafficking organization for another.").

366. Gibbons, *supra* note 223, at 9.

367. *See* Graham Boyd et al., *Marijuana Legalization: Does Congress Need to Act?*, THIRDWAY.ORG (June, 10, 2014), http://www.thirdway.org/report/marijuana-legalization-does-congress-need-to-act; LISA N. SACCO & KRISTIN FINKLEA, STATE MARIJUANA LEGALIZATION INITIATIVES: IMPLICATIONS FOR FEDERAL LAW ENFORCEMENT 5–7 (Dec. 4, 2014), https://www.fas.org/sgp/crs/misc/R43164.pdf.

368. Gonzales v. Raich, 545 U.S. 1, 42 (O'Connor, J., dissenting) (quoting

While the states may be "experimenting" with legalizing medical marijuana, the federal government will be watching and adapting, but when pressed will merely reiterate that under the CSA, medical marijuana use is still illegal.[369] The federal government's fluctuating position, as seen in this article, leaves the states little direction when determining policies and effectively extends to the states the power to regulate their own marijuana markets.[370] While California did not technically grant legal protections from federal law to patients, doctors, growers, or distributors by passing the Compassionate Use Act, in practice ninety-nine percent of all marijuana arrests happen at state or local level and not at the federal level.[371] Does this mean an effective end to federal marijuana prohibition has already occurred? It is unlikely that federal marijuana prohibition will end soon, though the inaction of Congress and the executive departments (the DOJ, IRS, and Financial Crimes Enforcement Network) seems to indicate that the prohibition may have already ended, in effect.[372] Only time will tell.

New State Ice Co. v. Liebermann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)).

369. *See* Boyd et al., *supra* note 367.

370. *Id.*

371. *See State Implementation*, *supra* note 263, at n.44 (citing *FEDERAL BUREAU OF INVESTIGATION, CRIME IN THE UNITED STATES: UNIFORM CRIME REPORTS* 1, 278–80 (2005), http://www2.fbi.gov/ucr/cius_04/documents/CIUS2004.pdf).

372. *See* Boyd et al., *supra* note 367.